

**TERTIARY STUDENTS' EXPERIENCES AND NEEDS RELATED TO
UNPLANNED PREGNANCIES AND THE TERMINATION OF
PREGNANCY: PRACTICE GUIDELINES FOR PSYCHOSOCIAL
SUPPORT**

by

LYNETTE CONRADIE

submitted in accordance with the requirements for
the degree of

DOCTOR OF PHILOSOPHY

In the subject

SOCIAL WORK

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF A.H. ALPASLAN

JANUARY 2019

DECLARATION

Name: Lynette Conradie
Student number: 41751671
Degree: DPhil Social Work

TERTIARY STUDENTS' EXPERIENCES AND NEEDS RELATED TO UNPLANNED PREGNANCIES AND THE TERMINATION OF PREGNANCY: PRACTICE GUIDELINES FOR PSYCHOSOCIAL SUPPORT

I declare that the above thesis is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.



30/01/2019

SIGNATURE

DATE

ABSTRACT

The prevalence of and increase in unplanned pregnancies (UPs) and the termination of pregnancy (TOP) amongst tertiary students (TSs) have been found to have a detrimental impact on students, their significant others, and tertiary institutions. UPs amongst TSs have been mentioned as one of the factors contributing to the problem of high dropout rates, which calls for an investigation of this phenomenon and strategies to address it.

Despite the need for support to TSs who find themselves in the predicament of an UP and/or TOP, a lacuna has been found with specific reference to practice guidelines from the ambit of social work to assist service providers (SPs) in the provision of psychosocial support services to the said students.

To explore and describe the experiences, support, and support needs of TSs presenting with UPs and/or TOPs from the perspectives of these students and the SPs rendering services to them, as well as to gather suggestions from them to inform practice guidelines for psychosocial support, the qualitative research approach, designs, and methods of data collection were used to collect data from six TS- and 23 SP-participants that were purposively recruited.

Presenting the findings against the backdrop of Schlossberg's Transition Process Model (Schlossberg, 2011 & 1981), adopted as theoretical framework for the study, the following emerged: Experiencing an UP and/or TOP is a traumatic crisis event for TSs, which rings in a transition resulting in imminent and fundamental changes in their academic and social life, relationships, outlook on life, and self-image, as well as a smorgasbord of feelings and emotional reactions such as shock, denial, guilt, shame, loneliness, depression and anger following this event. The UP-crisis is arrested by deciding how to manage it (either through parenting, foster care, adoption, or TOP). This decision-making process is perceived as difficult with the formal and/or informal convoy of support, or lack thereof, having a decisive influence

on the outcome of how the UP is managed. Apart from TS-participants' appraisal of the support that they received in dealing with this life event, they articulated several support needs and suggestions for themselves and other TSs alike. The SP-participants also offered several suggestions on how psychosocial support to a TS confronted with this phenomenon should be provided. The suggestions from both participant groups informed the practice guidelines to assist SPs in providing psychosocial support to TSs presenting with an UP and/or TOP. These guidelines focus specifically on how to establish a helping relationship with a TS presenting with the concern of an UP and/or a TOP, and how to assess and intervene in the situation, the self, the support, and the (coping) strategies surrounding the TS's UP and/or TOP.

In addition, recommendations for university policies on student pregnancies, social work practice, and further research were made.

KEY TERMS

Tertiary students; experiences; needs; unplanned pregnancy; termination of pregnancy; practice guidelines; psychosocial support; social work; Schlossberg's Transition Process Model.

ACKNOWLEDGEMENTS

I would like to express my sincere appreciation to the following people who accompanied me on this research journey. I could not have completed this endeavour without your support and encouragement. Thank you:

- Prof Nicky Alpaslan, my supervisor, for not allowing me to give up. I could not have done this without your expert leadership, wisdom and sacrifice and I am forever grateful to you.
- Lindi De Beer, for editing this thesis. Your efficiency, reassurance, kind understanding and advice in putting this report together is highly appreciated.
- Dr Huma Louw, for the professional independent coding.
- Alice Machele, specialist librarian, for assisting with my information search.
- My parents, Dries and Marina, who taught me that a dream only becomes a reality through hard work and determination.
- My daughter, Carla, for sharing my dream with me. Don't give up on yours!
- My two "sisters-from-different-mothers", Joany Jansen Van Rensburg and Lorika Kruger. Thank you for being my super-egos. Your care, understanding, love and motivation carried me through this process.
- All my friends, family members and colleagues for your constant interest, motivation and support.
- My research participants, for your willingness to avail yourself for this study and for sharing your experiences with me. Without you there would be no thesis.
- My Heavenly Father for providing me with the strength, perseverance and motivation to complete this journey.

I dedicate this study to my husband, Jacques. Your patience, quiet presence, unconditional love and endless cups of tea lifted me up and made the completion of this thesis possible. Thank you for being my strongest supporter, my best friend and my soul mate.

TABLE OF CONTENTS

DECLARATION	i
ABSTRACT.....	ii
ACKNOWLEDGEMENTS.....	iv
LIST OF ABBREVIATIONS	xxi

CHAPTER ONE: GENERAL INTRODUCTION AND ORIENTATION TO THE STUDY

1	1
1.1 INTRODUCTION	1
1.1.1 Unplanned pregnancies (UPs).....	2
1.1.1.1 The prevalence of and increase in UPs.....	2
1.1.1.2 Factors contributing to UPs	5
1.1.1.3 The disadvantages of UPs	10
1.1.1.4 The consequences of UPs	12
1.1.1.5 Options and decisions when dealing with UPs	17
1.1.2 Termination of pregnancy (TOP)	20
1.1.2.1 TOP as a consequence of an UP	20
1.1.2.2 The prevalence of and increase in TOPs	21
1.1.2.3 Multiple termination of pregnancies	23
1.1.2.4 Factors influencing the decision to terminate the pregnancy	26
1.1.2.5 Experiences and consequences of a TOP	30
1.2 PROBLEM FORMULATION	35
1.3 THE RATIONALE FOR THE STUDY.....	42
1.4 THE THEORETICAL FRAMEWORK ADOPTED FOR THE STUDY	44
1.4.1 Schlossberg's Model for analysing human adaptation to transition	46
1.4.1.1 Approaching the transition: Transition identification – its meaning, and the transition process	51
1.4.1.2 Taking stock of coping resources – The 4S-system (situation, self, support, and strategies).....	56
1.4.1.3 Taking charge: Strengthening one's resources	58

1.5	CLARIFICATION OF KEY CONCEPTS.....	58
1.5.1	Experiences.....	59
1.5.2	Guidance, guidelines, and practice guidelines.....	59
1.5.3	Needs	60
1.5.4	Post Abortion Stress/Syndrome (PAS)	61
1.5.5	Pregnancy	62
1.5.6	Service provider (SP).....	63
1.5.7	Social work	64
1.5.8	Social worker	64
1.5.9	Student	65
1.5.9.1	Adolescence, late adolescence, and the youth/young people	65
1.5.10	Support	66
1.5.11	TOP (also referred to/known as “abortion”)	68
1.6	OUTLINE OF THE RESEARCH REPORT	70
1.7	CHAPTER SUMMARY	72
 CHAPTER TWO: THE PROPOSED RESEARCH PLAN – AN INTRODUCTION....		73
2.1	INTRODUCTION	73
2.2	RESEARCH QUESTIONS.....	74
2.3	THE RESEARCH GOALS AND OBJECTIVES.....	76
2.4	RESEARCH METHODOLOGY.....	79
2.4.1	Research approach	80
2.4.2	Research design.....	84
2.4.2.1	The collective instrumental case study design	85
2.4.2.2	The phenomenological research design.....	86
2.4.2.3	The explorative, descriptive, and contextual strategy of inquiry	87
2.5	RESEARCH METHODS	89
2.5.1	Population, sample, and sampling techniques.....	89
2.5.2	Recruitment, screening, selection of participants, and preparation for data collection.....	93
2.5.3	Methods of data collection	100

2.5.4	Pilot testing of the data collection methods and data collection instruments	112
2.5.5	Method of data analysis	113
2.5.6	Ensuring the trustworthiness of the study and data verification	115
2.6	ETHICAL CONSIDERATIONS	118
2.6.1	Obtaining informed consent	120
2.6.2	Avoidance of harm	121
2.6.3	Right to privacy, confidentiality of data, and anonymity	122
2.7	CHAPTER SUMMARY	123

CHAPTER THREE: DESCRIPTION OF THE APPLICATION OF THE RESEARCH METHODOLOGY UTILISED IN THIS STUDY		125
3.1	INTRODUCTION	125
3.2	MY MOTIVATION FOR DESCRIBING THE APPLICATION OF THE RESEARCH METHODOLOGY APPLIED IN THIS STUDY	125
3.3	THE NATURE OF THE QUALITATIVE RESEARCH APPROACH	127
3.4	APPLICATION OF THE RESEARCH DESIGN	132
3.4.1	The collective instrumental case study design	133
3.4.2	The phenomenological research design	134
3.4.3	The explorative, descriptive, and contextual strategy of inquiry	135
3.5	APPLICATION OF THE RESEARCH METHODS	137
3.5.1	Population, sample, and sampling techniques	137
3.5.2	Participant recruitment	139
3.5.2.1	The pre-access phase in view of negotiating access to the fieldwork settings and potential participants	143
3.5.2.2	Negotiating entry to and cooperation from the different fieldwork settings	146
3.5.2.3	Negotiating access to the participants (namely SPs and TSs)	149
3.5.3	Pilot testing and data collection	152
3.5.4	Analysing the data	163

3.5.5	Verifying the data and techniques for ensuring the trustworthiness of the study and the research findings	166
3.6	APPLICATION OF THE ETHICAL CONSIDERATIONS	171
3.6.1	Obtaining informed consent	173
3.6.2	Avoidance of harm	174
3.6.3	Right to privacy, confidentiality of data, and anonymity	175
3.7	CHAPTER SUMMARY	177

CHAPTER FOUR: RESEARCH FINDINGS – THE EXPERIENCES, SUPPORT, AND SUPPORT NEEDS OF TSs IN RELATION TO THEIR UPs AND/OR TOPs, AS WELL AS THEIR SUGGESTIONS TO INFORM PRACTICE GUIDELINES FOR PSYCHOSOCIAL SUPPORT		179
4.1	INTRODUCTION	179
4.2	THE DEMOGRAPHIC DETAILS OF THE TSs WHO PARTICIPATED IN THIS STUDY	180
4.2.1	The Age Distribution of the TS-Participants	181
4.2.2	Participants’ qualifications enrolled for, year of study at the time of participating in the study and year of study in which the UP and/or TOP occurred	186
4.2.3	Place of residence of TS-participants during their studies and when their UP and/or TOP occurred	188
4.2.4	Province and Area where the TS-participants came from originally	190
4.2.5	Ethnicity and language distribution of the TS-participants	192
4.3	THE THEMES, SUB-THEMES, AND CATEGORIES THAT EMERGED FROM THE DATA ANALYSIS PROCESS	193
4.3.1	Theme One: Circumstances leading up to, and the feelings, emotional reactions, and life changes experienced following the UP-experience	195
4.3.1.1	Sub-theme 1.1: Participants’ accounts of the nature of their relationships prior to the UP	197
4.3.1.2	Sub-theme 1.2: Participants’ explanations of the reasons for their UPs	199

a)	Category 1.2.1: Lack of contraceptive use; negative attitudes about condom use; and the incorrect risk assessment about falling pregnant as explanations provided for UPs	200
b)	Category 1.2.2: Stopped using contraceptives because of the side-effects and the failure of the contraceptives used as reasons given for the UP	204
c)	Category 1.2.3: God knew that the participant needed somebody in her life to nurture due to the person she was as reason given for the UP	206
4.3.1.3	Sub-theme 1.3: Feelings and emotional reactions experienced on confirmation of the suspicion of the UP	207
a)	Category 1.3.1: Feelings of shock, denial, and disbelief experienced on confirmation of the suspicion of the UP	208
b)	Category 1.3.2: Feeling worried and stressed on confirmation of the suspicion of the UP	208
c)	Category 1.3.3: Feelings of fear of loss of the relationship with their partners and significant others experienced on confirmation of the suspicion of the UP	210
d)	Category 1.3.4: Feelings of guilt and shame experienced on confirmation of the suspicion of the UP	211
e)	Category 1.3.5: Feelings of loneliness experienced and withdrawal/isolation from others on confirmation of the suspicion of the UP	212
f)	Category 1.3.6: Feelings of disappointment and sadness experienced on confirmation of the suspicion of the UP	213
g)	Category 1.3.7: Feelings of anger experienced on confirmation of the suspicion of the UP	214
h)	Category 1.3.8: Mixed feelings experienced on confirming the suspicion of the UP	216
4.3.1.4	Sub-theme 1.4: Participants' accounts of how their lives changed following the UP	216

a)	Category 1.4.1: The UP forced a participant to grow up and become responsible	217
b)	Category 1.4.2: Participants' relationships with significant others ended and/or became strained.....	218
c)	Category 1.4.3: Participants' financial prospects became uncertain and caused stress	219
d)	Category 1.4.4: Participants' academic performance deteriorated and academic progression became uncertain as result of the UP ...	221
4.3.2	Theme Two: Participants' accounts of the decisions taken to deal with the UP, what informed their decisions, and the feelings and emotional reactions experienced afterwards	222
4.3.2.1	Sub-theme 2.1: Participants' decisions taken in dealing with their UPs.....	224
4.3.2.2	Sub-theme 2.2: Participants' accounts of the factors that influenced the decision taken in order to deal with the UP	226
4.3.2.3	Sub-theme 2.3: Feelings and emotional reactions experienced following the decision taken in order to deal with the UP.....	232
4.3.3	Theme Three: Participants' accounts of the nature of the support received in relation to their UPs and/or TOPs, how they experienced this support, and how they would have liked to be supported otherwise	236
4.3.3.1	Sub-theme 3.1: Participants' accounts of the on and off-campus professional and informal support sought and received	238
4.3.3.2	Sub-theme 3.2: Participants' accounts of how they experienced the on- and off-campus professional and informal support sought and received.....	241
a)	Category 3.2.1: Positive experiences related to the on- and off-campus professional and informal support sought and received.....	241
b)	Category 3.2.2: Negative experiences related to the on and off-campus professional and informal support sought and received.....	244

4.3.3.3	Sub-theme 3.3: Participants' accounts of what they would have liked to be different in terms of the on- and off-campus professional and informal support sought and received.....	246
a)	Category 3.3.1: A participant would have liked to have more information about the on- and off-campus support services available to her	246
b)	Category 3.3.2: Participants would have liked to have more support from their significant others	247
c)	Category 3.3.3: Participants would have liked to have more information about the different options available when dealing with an UP	249
d)	Category 3.3.4: Participants would have liked to be better prepared for the TOP-process and procedure.....	250
e)	Category 3.3.5: A participant would have liked to be less afraid of what she believed others were thinking or saying about the ordeal of her UP	252
4.3.4	Theme Four: Suggestions for psychosocial support to TSs presenting with an UP and/or TOP	252
4.3.4.1	Sub-theme 4.1: Participants' suggestions for medical and counselling support, peer support and education, awareness campaigns, as well as academic-related support to students with UPs and/or TOPs and suggestions to students to utilise this support	253
a)	Category 4.1.1: Suggestions for medical support offered to students presenting with an UP and/or TOP	254
b)	Category 4.1.2: Suggestions related to counselling support, peer-support and education, and awareness campaigns for students presenting with an UP and/or a TOP	258
c)	Category 4.1.3: Suggestions for academic-related support to students presenting with an UP and/or a TOP	265
4.4	CHAPTER SUMMARY	268

CHAPTER FIVE: RESEARCH FINDINGS – SPs’ PERCEPTIONS OF THE EXPERIENCES AND SUPPORT NEEDS OF TSs PRESENTING WITH UPs AND TOPs, THE SCOPES OF SUPPORT SERVICES OFFERED BY THEM, AND SUGGESTIONS INFORMING PRACTICE GUIDELINES FOR PSYCHOSOCIAL SUPPORT	271
5.1 INTRODUCTION	271
5.2 THE DEMOGRAPHIC DETAILS OF THE SP-PARTICIPANTS.....	271
5.3 THE THEMES, SUB-THEMES, AND CATEGORIES THAT EMERGED FROM THE DATA ANALYSIS PROCESS.....	276
5.3.1 Theme One: SPs’ perceptions about the prevalence, impact, and reasons for the occurrence of UPs and TOPs amongst TSs	280
5.3.1.1 Sub-theme 1.1: SPs perceive UPs and/or TOPs to be a prevalent social phenomenon amongst TSs	280
5.3.1.2 Sub-theme 1.2: The perceptions of SPs about the impact of UPs and TOPs on TSs.....	281
5.3.1.3 Sub-theme 1.3: SPs’ perceptions of the reasons for the occurrence of UPs and/or TOPs amongst TSs	282
a) Category 1.3.1: Engaging in high-risk sexual behaviour; contraceptive issues; peer pressure; lack of knowledge regarding sexuality; and unavailability of support services as reasons for the occurrence of UPs amongst TSs.....	283
b) Category 1.3.2: Academic, financial, parental, and/or partner pressures and lack of information on options to manage an UP as reasons for TOPs amongst TSs.....	286
5.3.2 Theme Two: SPs’ perceptions of the experiences and support needs of TSs presenting with UPs and/or TOPs	289
5.3.2.1 Sub-theme 2.1: SPs’ perceptions of the feelings and emotional reactions experienced by TSs presenting with UPs and/or TOPs	290
a) Category 2.1.1: SPs perceive TSs as being pressured and experiencing feelings of confusion about the UP and the management thereof	291

b)	Category 2.1.2: SPs perceive TSs to experience feelings of loneliness and lack of support	292
c)	Category 2.1.3: SPs perceive TSs as being afraid of the negative reactions of and abandonment by their significant others	293
d)	Category 2.1.4: SPs perceive TSs as experiencing feelings of guilt and shame.....	294
e)	Category 2.1.5: SPs perceive TSs as experiencing feelings of shock upon the confirmation of the suspicion of an UP.....	295
f)	Category 2.1.6: SPs perceive TSs as experiencing trauma as a result of the TOP-procedure.....	296
g)	Category 2.1.7: SPs perceive TSs as experiencing academic and financial pressure and stress.....	298
5.3.2.2	Sub-theme 2.2: SPs' perceptions of the support needs of TSs presenting with UPs and/or TOPs	301
a)	Category 2.2.1: SPs perceive TSs presenting with UPs and TOPs to be in need of counselling and support.....	301
b)	Category 2.2.2: SPs perceive TSs presenting with UPs and/or TOPs to be in need of on-campus medical support	303
c)	Category 2.2.3: SPs perceive TSs presenting with UPs and/or TOPs to be in need of academic support	304
5.3.3	Theme Three: The scopes of the support services offered by SPs to TSs presenting with UPs and/or TOPs	306
5.3.3.1	Sub-theme 3.1: SPs offer counselling as support service to TSs presenting with UPs and/or TOPs	306
a)	Category 3.1.1: The provision of crisis pregnancy counselling, post-abortion counselling, and bereavement counselling.....	307
b)	Category 3.1.2: Referral to and liaison with internal and external resources and the student's significant others.....	308
c)	Category 3.1.3: Life skills and psycho-education	311
5.3.3.2	Sub-theme 3.2: SPs offer medical support to TSs presenting with UPs and/or TOPs	313

5.3.4	Theme Four: SPs accounts of the resources available and obstacles encountered in rendering support services to TSs presenting with UPs and/or TOP	314
5.3.4.1	Sub-theme 4.1: Resources available to assist SPs in their service delivery to TSs presenting with UPs and/or TOPs.....	314
	a) Category 4.1.1: Peer/collegial support as a resource.....	314
	b) Category 4.1.2: Specialised and on-going training as resource	316
	c) Category 4.1.3: Being located in the right spot and having private offices available as a resource for service delivery	317
	d) Category 4.1.4: Having the option to refer students and having resources to refer to as a resource for service delivery.....	318
5.3.4.2	Sub-theme 4.2: Obstacles encountered by SPs in their service delivery to TSs presenting with UPs and/or TOPs.....	319
	a) Category 4.2.1: Lack of finances as an obstacle to service delivery.....	319
	b) Category 4.2.2: Staff-shortages and language and cultural barriers as obstacles to service delivery	320
	c) Category 4.2.3: The location and distance between student service departments at the tertiary institutions as an obstacle for service delivery	323
	d) Category 4.2.4: Facilitation of the termination of an UP with relative ease by the Choice on Termination of Pregnancy Act 92 of 1996 (South Africa 1996) as an obstacle to service delivery	324
	e) Category 4.2.5: TSs' non-utilisation of available resources as an obstacle to service delivery	325
	f) Category 4.2.6: Tertiary institutions' residential policies with regard to student pregnancy as an obstacle to service delivery	326
5.3.5	Theme Five: SPs suggestions for informing practice guidelines for psychosocial support to TSs presenting with an UP and/or TOP	327
5.3.5.1	Sub-theme 5.1: SPs' suggestions on the format and content of psychosocial support to TSs presenting with an UP and/or TOP	328

5.3.5.2	Sub-theme 5.2: SPs' additional suggestions for the offering of psychosocial support to TSs presenting with an UP and/or TOP	332
a)	Category 5.2.1: Psychosocial support to TSs should be enhanced through better networking, cooperation, and referrals between tertiary institutions, significant others, and community resources.....	332
b)	Category 5.2.2: The practice guidelines for psychosocial support to TSs presenting with an UP and/or TOP should be user-friendly, holistic, flexible, and disseminated to all relevant role players	334
c)	Category 5.2.3: The practice guidelines should inform tertiary institutions' policies related to student pregnancy	336
5.3.6	Unique Theme: SPs rendering support services to TSs presenting with UPs and/or TOPs should receive specialised and on-going training (specifically related to the phenomenon)	337
5.4	CHAPTER SUMMARY	338

CHAPTER SIX: PRACTICE GUIDELINES FOR PSYCHOSOCIAL SUPPORT TO TSs PRESENTING WITH AN UP AND/OR TOP		341
6.1	INTRODUCTION	341
6.2	POLICY FRAMEWORKS AND LEGISLATION UNDERPINNING THE PRACTICE GUIDELINES FOR PSYCHOSOCIAL SUPPORT TO TSs PRESENTING WITH AN UP AND/OR A TOP	342
6.2.1	The National AYHP, 2017.....	348
6.2.2	Family Planning Services: The NAFCI.....	349
6.2.3	The CTOP Act No 92 of 1996 and the CTOP Amendment Act No 38 of 2004.....	351
6.3	PRACTICE GUIDELINES FOR PSYCHOSOCIAL SUPPORT TO TSs PRESENTING WITH AN UP AND/OR TOP	354
6.3.1	Introductory remarks.....	354
6.3.2	Practice guidelines for establishing a therapeutic relationship with the TS presenting with an UP and/or TOP in order to provide psychosocial support.....	355

6.3.3	The purpose and focus of the psychosocial support provided to students presenting with an UP and/or TOP and the prerequisite knowledge base required by the SP	360
6.3.4	Practice guidelines for conducting a biopsychosocial assessment of the student presenting with an UP and/or TOP	365
6.3.5	Practice guidelines to intervene in the presentation of an UP	374
6.3.5.1	The Six-Step Model of Crisis Intervention as practice guideline to intervene in the presentation of an UP	374
6.3.5.2	The ETS programme as practice guideline to intervene in the presentation of an UP	379
6.3.5.3	Practice guidelines for revisiting the circumstances leading up to, and the feelings and emotional reactions following the UP-experience..	381
6.3.5.4	Practice guidelines for appraising and enhancing the psychosocial competence of the TS in the decision-making process regarding her UP	383
6.3.5.5	Practice guidelines for assessing and addressing the presence of depression and stress experienced as a consequence of the UP-experience and during the decision-making process in view of the management thereof	389
6.3.5.6	Practice guidelines for appraising and enhancing the resources and assistance available to assist during the UP and the decision-making process to deal with the UP	395
6.3.6	Practice guidelines for reflecting on the decision taken to manage the UP and the outcome thereof	401
6.3.6.1	Strategies for exploring, assessing, and intervening in the variables influencing the decision-making process related to the management of the UP and reflecting on the outcome thereof	401
6.3.6.2	Eagle’s Integrative Model for Brief Term Intervention in the Treatment of Psychological Trauma (adopted and adapted from Eagle, 1998)	409
6.3.6.3	“The Journey: a road to post-abortion recovery” (adopted and adapted from Thompson, 2005)	412

6.3.7 Conclusion.....	416
6.4 CHAPTER SUMMARY	416

CHAPTER SEVEN: SUMMARIES, CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS	418
7.1 INTRODUCTION	418
7.2 CHAPTER-WISE SUMMARY AND CONCLUSIONS	420
7.2.1 Summary and conclusions for Chapter One: General introduction and orientation to the study	420
7.2.2 Summary and conclusions for Chapter Two: The proposed research plan – An introduction	425
7.2.3 Summary and conclusions of Chapter Three: Description of the application of the research methodology utilised in this study	436
7.2.4 Summary and conclusions of Chapter Four: Research findings – the experiences, support, and support needs of TSs in relation to their UPs and/or TOPs, as well as their suggestions to inform practice guidelines for psychosocial support	446
7.2.5 Summary and conclusions of Chapter Five: Research findings – SPs’ perceptions of the experiences and support needs of TS presenting with UPs and TOPs, the scopes of support services offered by them, and suggestions informing practice guidelines for psychosocial support.....	455
7.2.6 Summary and conclusions of Chapter Six – Practice guidelines for psychosocial support to TSs presenting with an UP and/or TOP	462
7.3 LIMITATIONS INHERENT IN THIS STUDY	465
7.4 RECOMMENDATIONS.....	466
7.5 CHAPTER SUMMARY	470

List of References	472
---------------------------------	------------

LIST OF FIGURES

Figure 1.1: Schlossberg's Model for analysing human adaptation to transition	50
Figure 3.1: Synopsis of the process followed to gain access to the fieldwork sites and the research participants	142
Figure 6.1: Unhealthy grieving versus healthy grieving (Thompson, 2005:208)	413

LIST OF TABLES

Table 1.1: The prevalence of and increase in UPs, TOPs, and PAS at Tertiary Institution D from 2005 – 2016	36
Table 2.1: The task and research objectives of this research study	78
Table 2.2: Criteria of inclusion for selecting information-rich participants from the identified populations.....	92
Table 2.3: A tabulated overview of the strengths and limitations of in-depth _ interviews	102
Table 3.1: Synopsis of the referrals of potential TSs from the respective SPs	154
Table 3.2: Tabulated overview of the in-depth, semi-structured, face-to-face interviews that were conducted with the TS-participants.....	158
Table 3.3: An institution-wise synopsis of the SPs who participated in a focus group discussion or who were interviewed individually.....	160
Table 3.4: Tabulated overview of the focus group discussions and semi-structured, individual interviews that were conducted with the SP-participants.....	162
Table 3.5: Criteria and strategies employed in order to enhance the trustworthiness of the research findings of this study	171
Table 4.1: Age distribution of the TS-participants at the time of their participation in this study and when the UP and/or TOP occurred	181
Table 4.2: Participants' qualifications enrolled for, year of study at the time of participating in the study, and year of study in which the UP and/or TOP occurred	187

Table 4.3: Place of residence of TS-participants during their studies and when their UP and/or TOP occurred	189
Table 4.4: Province/area where TS-participants came from originally.....	190
Table 4.5: Overview of the themes, sub-themes, and categories that emerged from the data analysis process as consolidated during a consensus discussion	193
Table 4.6: Excerpts from the transcribed interviews of the TSs to substantiate sub-theme 3.1	238
Table 5.1: Demographic details of the SPs from the tertiary institutions	272
Table 5.2: Demographic details of the volunteer counsellors from the CPCC	274
Table 5.3: Overview of themes, sub-themes and categories that emerged from the data analysis process as consolidated during the consensus discussion	277
Table 6.1: Aspects of Integrated Social Welfare Services as depicted in the ISDM for Developmental Social Services and the Framework for Social Services and suggestions regarding practice guidelines for psychosocial support to TSs presenting with an UP and/or TOP	345
Table 6.2: An assessment tool for exploring and appraising the biopsychosocial functioning and wellbeing of the TS presenting with an UP and/or TOP	367
Table 6.3: The Six-Step Model of Crisis Intervention	375
Table 6.4: The RSE Scale (adopted and adapted for the guidelines).....	384
Table 6.5: Alpaslan's (1997:165) Synoptic Self-Assessment Framework (adopted and adapted for the guidelines)	385
Table 6.6: Example of a Self-Esteem Journal	388
Table 6.7: The PSS (adopted and adapted for the guidelines).....	393
Table 7.1: Summary of the task and research objectives formulated for this study and the conclusion on the realisation thereof	432

LIST OF ANNEXURES

Annexure A: Request for permission to conduct research

Annexure B: Invitation to participate in a research study: Tertiary students

Annexure C: Invitation to participate in a research study: Service providers

Annexure D: Informed consent: Tertiary students

Annexure E: Informed consent: Service providers

Annexure F: Interview guide: Tertiary students

Annexure G: Discussion guide: Service providers

Annexure H: Unisa Ethical Clearance Certificate

LIST OF ABBREVIATIONS

AYHP	Adolescent and Youth Health Policy
CBT	Cognitive Behavioural Therapy
CPCC	Crisis Pregnancy Care Centre
CSG	Child Support Grant
CTOP	Choice on Termination of Pregnancy Act
D&C	Dilation and curettage
DoE	Department of Education
DSD	Department of Social Development
DoH	Department of Health
ECT	Electroconvulsive Therapy
ETS	Equipped to Serve
EVA	Electric vacuum aspiration
FHN	Fundamental human need
HELTASA	Higher Education Learning and Teaching Association of South Africa
HIV	Human immunodeficiency virus
HODs	Heads of Departments
IDX	Intact dilation and extraction
IFSW	International Federation of Social Workers
ISDM	Integrated Service Delivery Model
MVA	Manual vacuum aspiration
NAFCI	National Adolescent Friendly Clinic Initiative
NGO	Non-governmental organisation
PAS	Post-abortion stress
PTSD	Post-traumatic stress disorder
PSS	Perceived Stress Scale
RSE Scale	Rosenberg Self-esteem Scale
SACSSP	The South African Council for Social Service Professions
SP	Service provider

STD	Sexually transmitted disease
STI	Sexually transmitted infection
TAS	Triage Assessment System
TOP	Termination of pregnancy
TS	Tertiary student
UN	United Nations
UNISA	University of South Africa
UP	Unplanned pregnancy
USA	United States of America
WHO	World Health Organization
WRHI	Reproductive Health and HIV Institute

CHAPTER ONE:

GENERAL INTRODUCTION AND ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The first chapter of this thesis is devoted to introducing or providing a backdrop to the topic chosen for investigation. The research problem identified will be indicated and the motivation for embarking on this research journey will be given. In addition, the theoretical framework adopted for the study will be introduced, the salient concepts central to this study clarified, and the chapter outline for this thesis provided.

The research questions derived from the identified research problem, as well as the goals and objectives formulated to plot the course of answering the stated questions, will be presented in Chapter Two of the report, where the proposed research plan for the study will be introduced.

To lay the foundation for this study, the topics of unplanned pregnancies (hereafter referred to as UPs) and the termination of pregnancy (hereafter referred to as TOP)¹ will be introduced generally and then narrowed down as it relates to tertiary students (hereafter abbreviated as TSs)².

Concerning the topic of UPs and by way of introduction, the following aspects are covered: the incidence and escalation of this phenomenon, the contributing factors, the disadvantages and consequences thereof, as well as the decision-making process and options when dealing with UPs. Concerning the phenomenon of TOP, the following will be discussed: TOP as a consequence of an UP; the prevalence of

¹ A detailed clarification of the concepts of UP and TOP is presented in Section 1.5.5 and 1.5.11 of this chapter.

² The client system group identified for this research study is TSs. According to the South African Council for Social Service Professions (SACSSP) (n.d.), client systems in social work refer to an individual, a family, a group of people, or a community receiving/utilising services from a practitioner in his/her professional capacity or from an organisation. The concept student, as it applies in this study, is clarified and elaborated upon in Section 1.5.9 of this chapter.

and increase in TOPs; multiple TOPs; factors influencing the TOP decision; and the experiences and consequences of a TOP.

1.1.1 Unplanned pregnancies (UPs)

In this sub-section, the prevalence of and increase in UPs; the factors contributing to UPs; as well as the disadvantages and consequences of UPs are indicated. This is followed by a discussion of the options and decisions when dealing with an UP.

1.1.1.1 The prevalence of and increase in UPs

Women in general regard a pregnancy as “unplanned”, “unintended”, or “unwanted” when one or more of the following variables are present (Wellings, Jones, Mercer, Tanton, Clifton, Datta, Copas, Erens, Gibson, Macdowall, Sonnenberg, Phelps & Johnson, 2013:1807-1808; Grussu, Quatraro & Nasta, 2005:107). These variables are:

- when the intention was not to become pregnant whilst on and/or after stopping the use of contraceptives;
- partner agreement not to become pregnant (or that the pregnancy is unwanted);
- lack of maturity in lifestyle; and
- not having reached a desired life stage.

There has been a **significant increase in UPs amongst adolescents and the youth³ worldwide**. The World Health Organization (WHO) (2011:2; 2009) estimates that about 16 million women between the ages of 15 and 19 give birth each year, accounting for approximately 11% of all births worldwide. For the age group 20 – 24 years, the UP rates increase with approximately 8 – 10% (WHO, 2015:155; Campero, Walker, Atienzo & Gutierrez 2011:2; Fatusi & Hindin, 2010:3).

In **sub-Saharan Africa**, several studies conducted in the past 10 years highlighted the prevalence of and increase in UPs. Bankole, Singh, Hussain and Oestreicher (2009:75)⁴, in their research on condom use for preventing unintended pregnancy, describe the prevalence and increase of this phenomenon as a “major health concern”, especially amongst young men and women between the ages of 15 and 29. The unwanted pregnancy rate in sub-Saharan Africa is estimated to be 20 – 40% (Wekesa, 2016:2777; Johnson & Madise, 2010:3; Stuart, 2009:412). The United Nations (UN), however, in their 2010 revision of world population prospects, found that fertility in sub-Saharan Africa stood at 5.1 births per woman in the 2005–2010 period (UN, 2011:12; Bearinger, Sieving, Ferguson and Sharma, 2007:1222). Adding

³ As mentioned earlier, the topic of investigation is focused on TSs. The findings of several research studies suggest that the general age of the majority of young people who make the transition from secondary education to tertiary education is 17 to 20 years. South Africa’s National Youth Policy 2015 – 2020 (South Africa, 2015) defines young people as those falling within the age group of 14 to 35 years, with the Adolescent and Youth Health Policy (2017) and several other authors (Isdale, Reddy, Winnaar & Zuze, 2016; Marteleto, Lam & Ranchhod, 2009:353; Schleicher, Harris, Catley & Nazir, 2009:507-508) describing the life stage from age 10 to 13 years as adolescence and 18 to 24 years as late adolescence. It is suggested that the average TS fits in the category described as “late adolescence” (Bhorat, Lilenstein, Magadla & Steenkamp, 2015; Saddock & Saddock, 2003:35; Lenz, 2001:302) with this life stage relating to Phase 5 (“Identity versus Identity diffusion”) of Erikson’s Psychosocial Development Theory (SAACHDE, 2010:2-4; Saddock & Saddock, 2003:35). The concepts student, adolescence, late adolescence, and youth is clarified in Section 1.5.9 of this chapter and an elaboration of the life stage of the TSs who participated in this study is presented in Chapter Four (Section 4.2.1) of this research report.

⁴ Said authors used data from the demographic and health surveys from 18 countries in sub-Saharan Africa in order to examine condom use and reasons for using the method at last intercourse among sexually active young men between 15 and 29 years of age. Their research findings indicated that most young men were aware of the condom (73% – 98%), but its use at last intercourse was quite variable, ranging from 6% in Madagascar to 74% in Namibia. In 10 countries, more young men reportedly used condoms only to prevent sexually transmitted infections (STIs) than to prevent pregnancy alone. In six countries, at least one third of the users used the method for both purposes. Use of the condom at last intercourse was associated with union status, education, residence, and exposure to television in at least two thirds of the countries.

to the discourse, Bongaarts and Casterline (2013:154) aver that in some sub-Saharan African countries, one in five young women give birth each year, so almost all of these women are likely to have had a child by the age of 20 years.

The prevalence of and increase in UPs referred to above was also found in studies in **South Africa** focusing on this topic (Christofides, Jewkes, Dunkle, McCarty, Shai, Nduna & Sterk, 2014; Human Sciences Research Council, 2008:1). Bello, Kielowski, Heederik and Wilson (2010:5) are of the opinion that the UP rate amongst women in South Africa could be as high as 61%. According to Macleod (2009:375-376), the percentage of women between the ages of 15 and 29 years who have ever been pregnant is estimated at about 15%. Of this percentage, an estimated 66% of these women confirmed that the pregnancy at the time of conception was unwanted (Pettifor, Rees, Kleinschmidt, Steffenson, MacPhail, Hlongwa-Madikizela, Vermaak & Padian, 2005, in Macleod, 2009:376). Mchunu, Peltzer, Tutshana and Seutlwadi (2012:426-427) conducted a cross-sectional population-based household survey amongst 3123 participants aged 18 – 24, in four of the nine provinces in South Africa (Eastern Cape, Gauteng, KwaZulu-Natal, and Mpumalanga), with the purpose of assessing the prevalence of UPs and the associated factors. They confirmed a high UP rate amongst the youth in the mentioned age group (it correlates with evidence from studies done in sub-Saharan Africa, which indicates that 35% of pregnancies in this age group were “unplanned, unwanted or untimed”) (Mchunu et al., 2012:426). Multiple factors, such as unsafe sexual practices and lack of educational goals, which contribute to the phenomenon of UPs, were also identified (Coetzee & Ngunyulu, 2015; Christofides et al., 2014; Mchunu et al., 2012:432-433).

Concerns about the prevalence of and increase in UPs (based on annual school surveys conducted by the Department of Education) led to the National Department of Education (DoE) placing teenage and adolescent pregnancy at the top of its priority list for, amongst others, identifying barriers to information and service delivery with the purpose of proposing policies and services needed to prevent UPs. This was

done after it was reported that an estimated 15740 learners fell pregnant during the 2015 academic school year (DoE, 2017).

Although a slight decline has since been noted in the pregnancy rates amongst adolescents and young women (Department of Health, 2017:12; Christofides et al., 2014; Statistics South Africa, 2008; Pettifor et al., 2005:1526-1528), several scholars agree that these rates still remain unacceptably high (Bongaarts & Casterline, 2013:154; Panday, Makiwane, Ranchad & Letsoalo, 2009:6). The current age specific fertility rate (defined as the number of births in a certain year per thousand to women in a specific reproductive age group) for 15 to 19-year-old women is estimated at 66/1000 (Christofides et al., 2014; Macleod & Tracey, 2009:7-8). This points to high fertility levels amongst South Africa's adolescents and young females (Coetzee & Ngunyulu, 2015; Mchunu et al., 2012:424).

In summary, the prevalence of and the increase in UPs amongst university students is collectively regarded by several authors, nationally and internationally, as a serious concern, especially given the consequences and costs that this phenomenon has for tertiary institutions and its role in affecting the throughput targets of tertiary institutions⁵ (Bongaarts & Casterline, 2013:154; Akintade, Pengpid & Peltzer, 2011:74; Miller, 2011:69-70; Macleod & Tracey, 2009:8-9; Naidoo & Kasiram, 2006:343; Panday et al., 2009:6-7; Patel & Kooverjee, 2009:562; Pettifor, Levandowski, MacPhail, Padian, Cohen & Rees, 2008:1267; Santelli, Orr, Lindberg & Diaz, 2009:25).

1.1.1.2 Factors contributing to UPs

Understanding the phenomenon of UPs calls for an exposé of the factors contributing to it (Shahry, Kalhori, Esfandiyari & Zamani-Alavijeh, 2016; Calvert, Baisley, Doyle, Maganja, Changalucha, Watson-Jones, Hayes & Ross, 2013). These factors, being

⁵ A discussion of the negative impact that UPs have for institutions of higher education is presented later in this section. Please refer to Section 1.1.1.3 and 1.1.1.4 in this regard.

determinants of sexual behaviour that often result in pregnancy, are described by several authors as diverse, interrelated, multifaceted, and interweaving (Bafana, 2010:19; Calvert et al., 2013; Macleod & Tracey, 2009:25; Panday et al., 2009:29). The ability of adolescent and young women to navigate their sexuality and prevent UPs therefore depends on and is influenced by the following:

- **Ignorance about and negative attitudes towards contraception as contributing factors to UPs.** Despite relatively easy and often free access to contraceptives, UPs continue to pose a challenge to reproductive health services. According to Sekgobela (2008:1), “an unwanted or unplanned pregnancy among the youth is the logical end result of unprotected sex or unsafe sexual practice.” Infrequent contraception use also plays a significant role and this can be attributed to the following perceptions: low pregnancy risk, not expecting to have sex, harbouring negative attitudes toward contraceptives based on previous experiences, and a partner’s unwillingness to use condoms (Seutlwadi, Peltzer & Mchunu, 2012:46; Benokraitis, 2005:319). In addition, a number of scholars cite contraceptive failure with reference to inconsistent or incorrect use of contraceptives or contraceptive method failure, as well as cultural and religious opposition to the use of contraception as reasons for UPs (Coetzee & Ngunyulu, 2015; Christofides et al., 2014; Mchunu et al., 2012:427; Naidoo & Kasiram, 2006:345; Sekgobela, 2008:3).
- **Gender power inequity as a contributing factor to UPs.** Gender power is a prominent feature in adolescent and youth relationships (Jewkes, Dunkle, Nduna & Shai 2010:43; Wood, Maforah & Jewkes, 1998:237). Such inequity, influenced and maintained by the historical and prevailing degrees of power that men still exert over women sexually, complicate some women’s ability to negotiate or demand condom use and is being highlighted as contributing factor to UPs (Jewkes et al., 2010:44; Mwaba & Naidoo, 2005:651).

In a study about the prevalence and patterns of gender-based violence among young women in Soweto, South Africa, Dunkle, Jewkes, Brown, Gray, McIntyre and Harlow (2004:235) found that a first coerced sexual intercourse encounter appears to be experienced by between 20 – 40% of adolescent and young women. They concluded that this state of affairs increases young women's vulnerability to pregnancy; it seriously reduces their ability to influence the timing, frequency, and circumstances of sex, the likelihood of contraception or condoms being used, and to regard their body and sexuality as domains over which they can exert control. Other scholars (Shahry et al., 2016; Mchunu et al., 2012:433; Jewkes et al., 2010:44) also make reference to the aspects highlighted by Dunkle et al. (2004:235).

- **Risk-taking behaviour as contributing factor to UPs.** Various studies confirm that TSs in South Africa are knowledgeable about the risks of contracting sexually transmitted diseases (STDs) and UPs due to unprotected sex (Seutlwadi et al., 2012:45; Patel & Johns, 2009:502; Patel & Kooverjee, 2009:561; Wechsberg, Luseno, Riehm, Karg, Browne & Parry, 2009; Badenhorst, Van Staden & Coetzee, 2008:113). The use and/or abuse of alcohol and/or other substances have also been found to significantly increase risk-taking behaviour, such as having sex without a condom (Seutlwadi et al., 2012:45-46; Patel & Johns, 2009:502; Patel & Kooverjee, 2009:562; Wechsberg et al., 2009; Badenhorst, Van Staden & Coetzee, 2008:113; Mwaba & Naidoo, 2005:654).

Sexual risk-taking behaviour, such as engaging in unprotected sex, is reported to be high amongst students as verified by the South African studies consulted (Coetzee & Ngunyulu, 2015; Naidoo & Kasiram, 2006:349). Despite the fact that high-risk sexual behaviour poses serious threats to TSs' psychosocial and academic lives, and their own concerns about their high-risk sexual behaviour, it seems that they lack the required skills to enforce safe sex or abstinence

(Mchunu et al., 2012:426; Badenhorst et al., 2008:114; Naidoo & Kasiram, 2006:349).

- **Peer pressure is another contributing factor to UPs.** Peer attitudes, peer pressure, and norms related to sexuality and culture significantly influence the sexual behaviour of adolescents and youth in that when they realise that their peers are sexually active, they are more likely to follow suit (Calvert et al., 2013; Sieving, Eisenberg, Pettingel & Skay 2006:13-19; Kirby, 2002:473-485). Kirby's study (2002:479-480) conducted in the United States of America (USA) with the purpose of identifying the most important antecedents associated with adolescent initiation of sex, contraceptive use, and pregnancy, points to the statistical significance of peer pressure in this regard. Another USA-study, by Sieving et al. (2006:18-19), arrived at a similar finding. Calvert et al. (2013), in their study about the prevalence of UPs among young women in Tanzania, identified peer pressure as one of the major risk factors contributing to this phenomenon. In addition, when a negative perception among peers regarding contraception such as condoms exists, young people will probably be less likely to use contraceptives (Reidy, Brookmeyer, Gentile, Berke & Zeichner, 2016:460). Strong peer pressure, to prove adult status, fertility, and manliness through pregnancy, exists. Culture plays a role in this regard, as a woman's worth, according to Zulu culture, often is equated with her fertility (Craig & Richter-Strydom, 1983:452). According to Panday et al. (2009:36) "sexual activity has come to define what it means to be successful as a young man". Success is often defined by sexual activity and young people therefore often receive significant pressure from their peers to engage in sexual activity and/or have multiple sexual partners (Reidy et al., 2016:462-463; Calvert et al., 2013; Akintade et al., 2011:77; Varga, 2003:164; MacPhail & Campbell, 2001:1615).
- **Limited access to resources and information contributing to UPs.** Empowering adolescents and young women with resources and information to negotiate sexuality, high-risk sexual behaviour, and the use of contraceptives

have been found to result in better rather than worse outcomes (Hollander, 2002; Singh & Darroch, 2000:22).

In exploring the topic of UPs, specifically the prevalence of UPs and assessing the use of contraceptives amongst university students at tertiary institutions in KwaZulu-Natal and Gauteng, South Africa, Coetzee and Ngunyulu (2015) and Naidoo and Kasiram (2006:345) conclude that a lack of communication by parents regarding sex and contraception plays a significant role in the prevalence of UPs. Fox and Inazu (cited in Naidoo & Kasiram, 2006:345) confirm “few parents gave much direct instruction about sexuality, sexual intercourse or contraception.” Talking about sexual matters is still seen as a taboo in some cultures. Another prevailing perception cited as a reason for avoiding discussions on sex and contraception is that speaking about it will give young people permission to have and experiment with sex. The result of this is that many youngsters discuss sex with their peers and/or get sex education from these peers and/or the media, who both can be regarded as unreliable and sensationalised sources (Mchunu et al., 2012:432-433; Macleod & Tracey, 2009:31-32).

- **Inability to control their environment as factor contributing to UPs.** A higher socio-economic status has been equated with greater access to high quality contraceptive services and better education, which has been found to influence the immediate context of pregnancy prevention (Jewkes & Christofides, 2008; Ratlabala, Makofane & Jali, 2007:28; Bowes & Macleod, 2006:16; Kirby, 2002:477). Low socio-economic variables, namely unemployment, low levels of income and education, as well as high levels of crime, have been identified as risk factors for early and higher pregnancy prevalence (Coetzee & Ngunyulu, 2015; Christofides et al., 2014; Mchunu et al., 2012:432; Panday et al., 2009:37).

- **Poverty as contributing factor to UPs.** Growing up in poverty and being subjected to dysfunctional schools may lead to women feeling that they have less to lose by becoming pregnant, therefore making them less motivated to prevent an UP (Mchunu et al., 2012:432; Scharwächter, 2008:192). A study conducted by Dinkelman, Lam and Leibbrandt (2008:59-60) regarding the impact of poverty among young adults in Cape Town, South Africa, confirmed that the socio-economic status of a community significantly predicts higher rates of unprotected sex, as well as early sexual début for males and females.
- **Educational disempowerment as contributing factor to UPs.** The 2003 South African Demographic and Health Survey (Department of Health, 2007) clearly shows that 15 to 19-year-olds who are achieving well below the expected level of educational attainment for their age are at much greater risk of pregnancy. It is confirmed by the 2016 South African Demographic and Health Survey (Statistics South Africa, n.d.), as well as several scholars (Mchunu et al., 2012:429; Akintade et al., 2011:74; Kaufman, Clark, Manzini & May, 2004:268), that unintended pregnancy interferes with educational attainment, with the costs related to pregnancy often discounted by young people when they are confronted with the realities of not being able to complete their education or struggling to find employment. A willingness to take greater risks, which could result in unwanted pregnancies and/or being infected with the human immunodeficiency virus (HIV), has been identified because of these feelings of disempowerment (Mchunu et al., 2012:426).

1.1.1.3 *The disadvantages of UPs*

The disadvantages of UPs are many. Women with UPs reported higher levels of anxiety, depression, postnatal depression, and postnatal psychological problems (Grussu et al., 2005:113). A study conducted by Kilwein and Looby (2017:102) amongst college students in the USA, as well as studies conducted by Gama (2008) and Patel and Kooverjee (2009:556) amongst students enrolled at an institution of

higher education in KwaZulu-Natal, South Africa, confirmed that these disadvantages also apply to TSs. These findings, in addition, also confirmed that students confronted with an UP were more likely to smoke and use alcohol during their pregnancies, and were at a higher risk of inadequate prenatal care.

The increased levels of negative moods in mothers with UPs can affect the quality of the attachment bond that develops between the mother and the baby (Upadhyia & Ellen 2011:538; Pearce & Ayers, 2005:90). Children from single mothers with UPs are less likely to finish high school; they experience more health problems; and the poverty rate for single mothers is 12 times higher than that of married couples (Wise, Geronimus & Smock, 2017:10; Kirby, 2007; Shaw, Lawlor & Najman, 2006:2528; Benokraitis, 2005:317).

UPs pose a multiplicity of problems for both students and academic institutions (Upadhyia & Ellen, 2011:538; Naidoo & Kasiram, 2006:341). Despite the assumption that TSs have a fundamental understanding of the biology of the reproductive system; conception, contraceptives and their use in preventing UPs (Sekgobela, 2008:3), student pregnancies remain a reality and increase annually (Mantell, Smit, Exner, Mabude, Hoffman, Beksinska, Kelvin, Ngoloyi & Leu, 2015:1130; Tladi & Jali, 2014:275). While admitting to gaps in the accuracy of students' knowledge or skill level regarding correct contraceptive use, several scholars aver that the lack of education and information on these matters could not be used as a legitimate reason for pregnancy amongst this cohort (Mantell et al., 2015:1134; Upadhyia & Ellen, 2011:539; Abiodun & Balogun, 2009:147-148; Bankole, Ahmed, Neema, Quedraogo & Konyani, 2007:206).

Despite efforts to prevent UPs through education and providing accessible reproductive health advice, the legalising of TOPs, and supplying contraceptives and information on other birth control techniques, UPs amongst TSs still occur. Despite the fact that they are regarded as intelligent and well aware that a pregnancy could disrupt their studies and/or force them to leave university, all the means and

motivations for preventing conception still does not prevent UPs (Calvert et al., 2013; Jewkes & Christofides, 2008; Sekgobela, 2008:3).

Students in general often experience adjustment problems that may include difficulty in establishing identity and independence, specifically in a multi-cultural environment; relationship problems; stress and anxiety, mainly caused by fear of failure; depression; and difficulty in developing purpose and integrity, which could include motivation and self-discipline (Calvert et al., 2013; Mahlangu & Silaule, 2009:6). Being a pregnant student at a tertiary institution will result in even greater challenges.

The South African Government's focus on correcting social imbalances from the past has created educational and labour market opportunities for the previously disadvantaged, especially young Black females, in the form of study bursaries and affirmative action employment. Female students' chances of completing their studies and finding corporate employment can however be derailed by the emotional turmoil and logistical obstacles caused by UPs (Mantell et al., 2015:1133; Macleod & Tracey, 2010:21; Oosthuysen & Mfomande, 2008:2).

1.1.1.4 The consequences of UPs

Several scholars aver that pregnancy among adolescents and the youth is mostly unplanned (Calvert et al., 2013; Panday et al., 2009:26; Kirby, 2007). The experience of an UP at tertiary level often coincides with other transitions, such as the educational transition from secondary to tertiary education, but also the transition from adolescence or late adolescence to young adulthood (Lane, 2015:30; Jordán-Conde, Mennecke & Townsend, 2014:356-357; Santrock, 1998:24). These transitions⁶ can be interpreted as a crisis in itself, which is further compounded by an UP that has the potential to disrupt the equilibrium of the student's academic, social, relational, and family life even further (Tabane & Mmapheko, 2015:4; Daley, 2012:39;

⁶ The aspect of "transition" is elaborated upon in Section 1.4 of this chapter where the theoretical framework for the study is introduced. A detailed discussion of some of the transitions faced by TSs is also presented in Chapter Four of this research report.

Adams & Williams, 2011:1879; Sodi, 2009:17; Skinner, Smith, Fenwick, Hendriks, Fyfe & Kendall, 2009:52). It very often also results in negative consequences for the young mother and her child (Shahry et al., 2016; Calvert et al., 2013; Macleod & Tracey, 2010:21; Kirby, 2007; Finer & Henshaw, 2006:136).

The **consequences of UPs at tertiary level** are extensive and students face many difficulties, such as the following:

- Disruption of academic life and/or derailment of academic programme: Whilst students generally perceive the rules and regulations as set out by tertiary institutions related to UPs and the management thereof as too strict and non-accommodating, student pregnancies account for a high dropout rate at higher education level (Gama 2008:26; Matsolo, Ningpuenyeh & Susuman, 2016). This results in serious financial costs being incurred by the institution, the family, and the individual. Throughput targets of the institution are affected and, according to Naidoo and Kasiram (2006:341), this “may leave a trail of deficits that are difficult to manage, together with a bruised public image that impacts negatively on student intake” (Calvert et al., 2013; Macleod & Tracey, 2010:22).

Data related to the number of TSs in South Africa who go on to complete their academic qualification after an UP are not available, but a research study examining the factors associated with pregnancy-related dropouts of schoolgirls at several secondary schools in KwaZulu-Natal, South Africa, was conducted by Grant and Hallman (2006:371). They found that despite progressive legislation in South Africa allowing and enabling young women to return to school (such as the DoE’s Draft Policy on the Prevention and Management of Learner Pregnancy, 2018 and the Measures for the Prevention and Management of Learner Pregnancy, 2007), only a third of scholars (teenage mothers) re-enter the schooling system post-pregnancy. Macleod and Tracey (2010:20-21) concur with this finding by describing the relationship between early, unintended pregnancy and the completion of one’s education, as “complicated... with a

substantial minority of pregnant or mothering young women” completing their education.

The findings from the studies by Macleod and Tracey (2010:20-21) and Grant and Hallman (2006:371-372) referred to in the previous paragraph seem to resonate with similar findings from the research studies conducted by Matsolo et al. (2016); Badenhorst, Van Staden and Coetzee (2008:111); Gama (2008:17); and Naidoo and Kasiram (2006:349). These research studies explored sexual trends and the prevalence of UPs among TSs in KwaZulu-Natal, the Free State, and Gauteng in South Africa. The effects of UPs, with reference to the universities’ throughput and enrolment rates, were also explored and corresponding findings from the mentioned studies were that UPs at tertiary level impact negatively on students’ success rates.

- Another consequence, experienced more at a psychosocial level, is that the student and her family might lose their standing in the community because of the shame of an UP, an illegitimate child, or trauma upon also being diagnosed with HIV following the UP (Naidoo & Kasiram, 2006:341). Wiemann, Rickert, Berenson and Volk (2005:362) state in this regard that “the age old practice” of sending pregnant girls away to stay with relatives has been done away with. Adolescents and young women who fall pregnant often remain at home or in their community, with this increased visibility resulting in an added stigma (Calvert et al., 2013; Upadhya & Ellen, 2011:538).
- An economical consequence: The absence of education may result in a young mother lacking job skills, making it difficult for her to find and keep a job (Sekgobela, 2008:2). Several authors (Berglas, Brindis & Cohen, 2003; Hoffman, in Panday et al., 2009:27; Shahry et al., 2016) confirm that unsatisfactory labour force earnings are a reality for young women who have had an UP. This could lead to these women being obstructed by the lack of education and inexperience from earning a sound living. UPs therefore could

disrupt the educational and occupational outcomes of young women and this often exacerbates poverty, a consequence presented next (Wise et al., 2017:9; Calvert et al., 2013; Panday et al., 2009:27).

- An UP could result in poverty and create a dependency on the welfare system in terms of relying on the Child Support Grant (CSG) due to the inability to find and keep a decent paying job, or only getting a low-paying job (Calvert et al., 2013; Macleod & Tracey, 2010:21; Panday et al., 2009:27; Oosthuysen & Mfomande, 2008:23; Sekgobela, 2008:2). Although early childbearing does not necessarily lead to poverty, poverty and growing up in disadvantaged circumstances have been identified as incentives to avoid an UP/early motherhood (Kearney & Levine 2007). An UP could worsen the economic situation of young women (Shahry et al., 2016; Shaw et al., 2006:2531).
- More unwanted UPs: The prevalence of frequent pregnancies is high among African women, thus seriously lessening their availability for educational pursuit, particularly at the higher education level (Calvert et al., 2013; Martineau 1997:391). Panday et al. (2009:27) aver that women who have had an unintended pregnancy at a young age or who begin childbearing in their teenage years could be more at risk of having more children over a short period of time than older and/or married women (Wise et al., 2017:11-12; Calvert et al., 2013).
- Students with UPs who decide to get married are more likely to get divorced than adults who planned their families (Sekgobela, 2008:2). An early and/or unintended pregnancy furthermore affects the marriage prospects of young women (Upadhya & Ellen, 2011:539; Ashcraft & Langin, in Panday et al., 2009:27).
- The threat of violence or physical abuse from men is another consequence resulting from UPs that is worth mentioning. Various scholars (Kissen, Anderson, Kraft, Warner & Jamieson, 2008:366; Sekgobela, 2008:2) point to this

and underscore the fact that an UP, especially at a young age, has been associated with domestic violence. Young mothers tend to be more economically vulnerable and dependent on their partners, thus often exposing them to sexual and/or physical violence (Shahry et al., 2016; Upadhya & Ellen, 2011:539; Macleod & Tracey, 2010:26-27).

- Depression, which can lead to alcohol or drug abuse, is noted as another consequence of UPs (Macleod & Tracey, 2010:22; Grussu et al., 2005:113; Pearce & Ayers, 2005:90). This can, amongst others, be attributed to the stigma still attached to this phenomenon, despite its normalisation in many communities in South Africa. Many women still face embarrassment, discrimination, and judgement upon learning of their UP (Shahry et al., 2016; Panday et al., 2009:27; Varga, 2003:166).

The experience of depressive symptoms as a consequence of an UP seem to be in accordance with the findings of several other research studies which confirmed the negative emotional impact of an UP. Story (1999:47) conducted research among college students at a tertiary institution in Virginia, USA, with the purpose of exploring the emotional effects of an UP. She identified several negative emotional effects resulting from this phenomenon, namely sadness, despair and shame. Her findings resonate with the findings of Grey (2014:1201) as well as Moore, Overstreet, Kendler, Dick, Adkins and Amstadter (2017:109), who conducted research amongst female students at the Virginia Commonwealth University in Richmond, USA, and the Appalachian State University in North Carolina, USA, respectively. These students, who had experienced UPs, identified specific UP-related stressors, namely stigma; fear; failing to successfully complete their studies; and anxiety regarding what to do about their UPs. The prevalence and experience of trauma as a result of risky sexual behaviour (including UPs as a consequence) was also highlighted by Moore et al. (2017:109). The aforementioned authors postulate that many, if not most, of the adolescent and young women confronted with an UP experience a

significant number of long-term effects (effects that last a year or more), of which the most prevalent are feelings of guilt, shame, and fear of being stigmatised, socially marked, or judged negatively by peers and family (Moore et al., 2017:108). The influence of these negative effects on academic performance and educational attainment specifically are repeatedly reiterated, with the feelings and emotions being compared to the experience of personal sorrow and grief (Moore et al., 2017:108; Grey, 2014:1199; Story, 1999:47).

1.1.1.5 Options and decisions when dealing with UPs

An unmarried student experiencing an UP finds herself in the midst of a multifaceted crisis for which she has to find a solution as soon as possible. None of the available options, namely parenting, adoption, foster care or the termination of the pregnancy, are easy. The decision she makes now, in one set of circumstances, might not be the same one that she would make at a different stage or place in life (Grey, 2015:737; Bezuidenhout, 2004:38).

Should she choose parenting, her decision tends to be influenced by the willingness of her family or partner to support her and care for her child while she is completing her studies. Research findings (Grey, 2015:737; Naidoo & Kasiram, 2006:344) in this regard indicate that the majority of parents react negatively to the news that their daughter is pregnant, as these parents often make significant financial sacrifices to maintain their child at university.

Depending on the family's financial situation, this could be placing an extra burden on parents or other family members, as they might not have planned to care for or support a child at that time in their life (Grey, 2015:736; Benokraitis, 2005:499).

Regarding partner support, it seems that many partners tend to either suggest terminating the pregnancy or offer assistance to the child and mother in different ways, such as financial support, but no emotional or practical involvement/support

(Grey, 2015:737; Naidoo & Kasiram, 2006:347). Research studies conducted in this regard conclude that female students confronted with an UP generally perceive their partners to be unsupportive, blaming them for the crisis, denying fatherhood (Grey, 2015:738; Richter, Norris & Ginsburg, 2006:1-2), and/or accusing the female of unfaithfulness (Grey, 2015:738; Naidoo & Kasiram, 2006:347).

If the student with an UP chooses adoption, the different types and forms of adoption have to be considered. Will she choose a public or a private adoption, and will the adoption be open or closed? With a public adoption, children are placed in the child welfare system and the adoption is organised through a government agency, such as the Department of Social Development, or through a child and family welfare service or non-governmental organisation (NGO) providing adoption services. With a private adoption, the process is organised through private social service organisations or social workers in private practice. With kinship adoption, children are placed with relatives by either an adoption agency or by the birth parents (Rochat, Mokomane & Mitchell, 2016:124; Benokraitis, 2005:305).

An open adoption involves sharing of information between the adoptive and birth families throughout the child's life, while all information remains confidential with a closed adoption. In the case of a closed adoption, no parties are identified or have access to any information. A semi-open adoption allows for some communication of the members through a mediator (Rochat et al., 2016:125; Benokraitis, 2005:306).

Adoption, according to Rochat et al. (2016:125) and Benokraitis (2005:307) may affect affects all the members of the adoption triad (the birth parents, the adoptive parents, and the adoptee) in the following ways:

- The birth parent(s)/young mother might experience ambivalence about giving the baby up for adoption, grieve the loss of the baby, doubt their/her decision in years to come, or may be disappointed if the adoptive family does not live up to their/her expectations.

- Adoptive parents might not have the medical history of the child's biological family, which could impact negatively on them financially or emotionally. They may not have the financial and/or emotional resources/support to deal with an issue, such as a hereditary or genetic health problem. (Walkner & Rueter, 2014:880). They could also face the possibility of future interferences or attempts of involvement from the birth parent(s) and possible contact between the birth parents and the child.
- Adopted children may experience identity confusion, they might need to know more about their biological parents, the available information about their biological parents could be limited, and they may feel rejected by the birth parents.

Should it be concluded that the TS (and/or her immediate family) is unable to adequately provide for her child, foster care could be considered as an option to manage an UP. This process is a formal, statutory process facilitated by a social worker with the purpose of providing substitute family care for a child who cannot be sufficiently cared for at his/her home of origin (Dhludhlu & Lombard, 2017:165; Fortune, 2016:7) and is considered to be vulnerable and in need of care. Foster care is not considered permanent, but it may be long-term in specific legal cases with the State retaining guardianship of the child during this interim period of care. Little is known about the public perceptions, beliefs, and experiences informing the decision to foster (Rochat et al., 2016:120) and the process within the South African context is often described as one that is characterised by logistical complications, long delays, and “not providing a sustainable alternative” (Fortune, 2016:9). This option is normally used until a child can be reunited with his/her parent(s), permanently adopted, or reaches adulthood (Rochat et al., 2016:121).

TOP is seen as a relatively reliable indicator that a pregnancy is unwanted (Grey, 2014:1204; Macleod & Tracey, 2010:28). I will therefore continue this discussion with a description of the relevant and applicable issues related to this concept.

1.1.2 Termination of pregnancy (TOP)⁷

The topic of TOP will be introduced by a discussion of this phenomenon as a primary consequence of an unintended pregnancy. This discussion will be followed by a presentation of the prevalence of and increase in TOPs; multiple TOPs; the factors influencing the TOP decision; and the experiences and consequences related to a TOP.

1.1.2.1 TOP as a consequence of an UP

UPs can, and very often do, lead to TOPs (Wheeler, Zullig, Reeve, Buga & Morroni, 2012:154; Patel & Kooverjee, 2009:550-551; Sekudu, 2001:2). According to Hodes (2016:80) and Wheeler et al. (2012:154-155), the option to terminate is associated with having an UP, with 92% of TOPs resulting from UPs. Research furthermore indicates that TOPs is particularly common among schoolgirls and university students (Hodes, 2016:80; Panday et al., 2009:25; Steinberg & Russo, 2009:500).

In November 1996 the Choice on Termination of Pregnancy (CTOP) Act 92 of 1996 (South Africa, 1996) was promulgated in South Africa. This Act replaced the Abortion and Sterilisation Act 2 of 1975 (South Africa, 1975), which provided limited access to TOP services under very particular circumstances, such as when the mother's life was in danger. This Act was viewed by many as restrictive and with inaccessible provisions, which explains why many women who considered a TOP resorted to unsafe TOPs (Lince-Deroche, Constant, Harries, Blanchard, Sinanovic & Grossman, 2015:339; Mdeleleni-Bookholane, 2007:245).

The CTOP Act 92 of 1996 (South Africa, 1996) and the CTOP Amendment Act 38 of 2004 (South Africa, 2005) promote reproductive rights and extend freedom of choice

⁷ Clarification of this concept is provided in Section 1.5 of this chapter. An overview of TOP services currently applied in practice is presented in Chapter Six. It is recommended that this discussion be read in conjunction with the discussion presented in Chapter Six.

by affording every woman, from the age of 12 years old, the right to choose whether to terminate her pregnancy before 12 weeks of gestation. The CTOP Act 92 of 1996 (South Africa, 1996) further intends to ensure that TOP services (at approved health service facilities) are available and accessible to all women who need them. Within this Act it is emphasised that TOP should not be a form of contraception or population control. The CTOP Act 92 of 1996 (South Africa, 1996) determines the circumstances under which a pregnancy may be terminated and it makes provision for non-compulsory counselling before, during, and after the TOP, therefore aiming to assist women in making an informed decision. Various research studies found that the introduction of the CTOP Act 92 of 1996 (South Africa, 1996) on 1 February 1997 has resulted in a reduction in the number of unsafe TOPs, as well as a reduction in the maternal mortality rate due to unsafe TOPs (Hodes, 2016:82; Harries, Cooper, Strebel & Colvin, 2014:16; Mdeleleni-Bookholane, 2007:245; Ratlabala et al., 2007:26; Poggenpoel & Myburgh, 2006:731).

1.1.2.2 The prevalence of and increase in TOPs

It is purported that up to 150 000 pregnancies are terminated globally every day because they are unintended and unwanted (Harries, Gerdt, Momberg & Greene Foster, 2015:3; Sekudu, 2001:2). Estimations by the WHO (2011:2) indicate that nearly 20 million women worldwide resort to TOPs annually (Hodes, 2016:81; Dahlbäck, Maimbolwa, Kasonka, Bergström and Ransjö-Arvidson, 2007:655). It is reported that 4% of these TOPs are done by women between the ages of 19 and 24, with 25% of these TOPs occurring in Africa (Macleod, Chiweshe & Mavuso, 2016:1097).

Differences in opinion regarding the actual number of TOPs seem to exist, however. Roberts, Moodey and Esterhuizen (2004:441) suggest that annually there are closer to 50 million TOPs performed worldwide, of which approximately 53 000 are performed in South Africa.

The figures presented by Roberts et al. (2004:441) above are confirmed by more recent Ipas statistics⁸ which indicate that approximately 529410 women have had safe and legal TOPs in South Africa since the introduction of the TOP legislation in 1997 (Health Systems Trust, n.d.; Ipas, n.d.). The findings of several other recent research studies (Hodes, 2016:83; Lince-Deroche et al., 2015:342; Wheeler et al., 2012:157) are in agreement with the Ipas statistics, but the scholars of these studies also emphasise the prevalence and high rates of unsafe TOPs, despite the legalisation of this phenomenon. A study conducted by Mosley, King, Schultz, Harris, De Wet and Anderson (2017) about the attitudes of South Africans regarding abortion confirmed that barriers to safe TOPs still exist (also see Harries et al., 2014:16). These barriers are opposition-based, founded on religious and moral beliefs, and also connected to limited access to safe TOP services (Lince-Deroche et al., 2015:342).

The high rates of TOPs specifically among university students worldwide have also been documented. Curley and Johnston (2013:281) explored the characteristics and severity of psychological distress after abortion among female students registered at two universities in Montreal, Canada. They found that of the 151 students aged 18-35 who participated in their study, 89 have had a TOP. In a descriptive, cross-sectional study conducted by Gelaye, Taye and Mekonen (2014) among female students at the Wolaita Sodo University, Ethiopia, it was found that the rate of abortion among students was 65 per 1000 women, making it three fold the national rate of abortion for Ethiopia (23/1000 women aged 15-44). The purpose of the study by Gelaye et al. (2014) was to determine the magnitude and risk factors of abortion. Data was collected from 493 randomly selected female students using structured and pre-tested questionnaires. Aside from confirming the high rate of TOPs amongst TSs, the authors also deduced that 50% of these abortions took place under unsafe circumstances (Gelaye et al., 2014).

⁸ Ipas is an abbreviation for International Pregnancy Advisory Services (Ipas, n.d.), a global NGO founded in 1973. Based in Johannesburg, Ipas South Africa is currently the nation's only NGO that focuses exclusively on abortion care and strives to create an environment in which all men and women can enjoy the highest possible standard of sexual and reproductive health.

The prevalence of TOPs amongst TSs resonates with the findings of another study conducted amongst TSs in this regard. Naidoo and Kasiram (2006:348), in their exploration of the occurrence of UPs amongst students at the University of KwaZulu-Natal, aimed to develop an understanding of the factors that influence this phenomenon. The participants in their study were 30 students who received services from the student counselling unit at the university. Several themes, including details of the pregnancy, risk-taking behaviour, and sources of support, were explored. With regard to the decision/outcome of the UP, the finding of this study confirmed that “most of the participants” (63%) opted to terminate rather than continue with the pregnancy. Of the remaining 37% (11) participants who decided to continue with their pregnancy, three continued simply because their pregnancies were too advanced to terminate. The rest of the students continued because of religious beliefs or out of fear of the termination (Naidoo & Kasiram, 2006:348).

The phenomenon of TOP, despite the legal status thereof in South Africa, remains a prevalent “silent” problem that is grossly under-reported among women in general (Mosley et al., 2017; Harries et al., 2014:16; Dahlbäck et al., 2007:655). This is also true for TSs who choose to terminate their UPs (Hodes, 2016:80; Gelaye et al., 2014; Curley & Johnston, 2013:283). The prevailing stigma attached to TOP and the sensitive nature surrounding it limits data sources and accurate information on the occurrence of TOPs (Bledsoe, Jordan, West & Reed, 2016:392; Macleod et al., 2016:1097).

1.1.2.3 Multiple termination of pregnancies

Multiple pregnancy terminations (also known as repeat TOPs/abortions) are of particular significance, as this phenomenon has been found to be on the increase worldwide (Pestvenidse, Berdzuli, Lomia, Gagua, Umikashvili & Stray-Pedersen, 2016:86; Mavis, Krishnamoorthy & Dongre, 2015:1155; Picavet, Goenee & Wijsen, 2013:327; Palanivelu & Oswal, 2007:832).

Statistics reveal that the number of women that have had two or more TOPs has risen to its highest ever level worldwide (Picavet et al., 2013:328; Private Healthcare UK, 2008). It is estimated that approximately 32% of women between the age of 18 and 24 – the age group generally inclusive of TSs (Rowlands, Cleland & Trussel, in Rowlands, 2014:197; Picavet et al., 2013:328) – who choose to terminate their pregnancies have had one or more previous terminations. Tietze (in Rowlands, 2014:196) notes in this regard that after abortion law is liberalised in a given country “...an increase in the proportion of women having more than one abortion occurs over time”. Some countries such as England and Wales, in attempt to increase the quality of local services to address the phenomenon of TOPs and repeat TOPs specifically amongst women younger than 25, have consequently introduced a ‘repeat abortion indicator’ (Rowlands, 2014:193).

The trend of repeat TOPs has also been reported on in South African studies in this regard. A research study conducted by Lang, Joubert and Prinsloo (2005:53), with the intention of determining the profile of 750 women, aged 15 to 47 years, seeking a TOP at the Reproductive Unit of the National Hospital in Bloemfontein, South Africa, found that one fifth (19.1%) of the participants reported having had previous terminations. Lang et al. (2005:53) also explored the question of whether the TOP is being used as a family planning method. In this regard, they found that 16.6% of the participants considered a TOP a family planning method. “Worryingly high” repeat rates associated with low contraceptive use and high HIV-prevalence was furthermore reported in a study conducted by Mphatswe, Maise and Sebitloane (2016:153) about the prevalence of repeat pregnancies and TOPs among teenagers in KwaZulu-Natal.

As with TOPs, it is suspected that the estimates regarding multiple TOPs are not a true reflection on the prevalence of this phenomenon (Pestvenidse et al., 2016:85; Mavis et al., 2015:1154; Faúndes, Rao & Briozzo, 2009:164; Faure & Loxton, 2003:35-36). According to Rowlands, (2014:196) “substantial under-reporting occurs due to concerns about the stigma attached to repeat TOPs.” One TOP might be

“excused” or “forgiven”, but repeat TOPs are often described as “repulsive” and met with exasperation and indignation (Picavet et al., 2013:331).

The following explanations as to why a woman would have multiple TOPs was offered by several counsellors rendering support services to women who have had more than one TOP. This information was gathered from volunteer counsellors at a specific crisis pregnancy care centre (hereafter referred to as the CPCC) as well student counsellors at the student counselling units of two of the tertiary institutions who participated in this research study (Tertiary Institutions A & D)⁹:

- Many women who terminate feel the urge to get pregnant again – in other words, the need for a “replacement” or “atonement” baby arises.
- Once pregnant again, they often realise that the same circumstances that led to the first TOP are still in place. Hence, another TOP follows.
- Often the mother, pregnant for the second time, thinks “I aborted my first child. I’m not worthy of being a mother. I don’t deserve this child.” She then goes to get another TOP. Repeat terminations are a sign of ambivalence, and at times, of self-punishment.
- Repeat terminations and replacement pregnancies seem to be two common ways in which women re-enact elements of their underlying and, very often, unresolved previous trauma.

The main reason, however, for the prevalence of and increase in repeat TOPs is that, for some women, easy access to TOP services fosters a careless attitude to contraception and the TOP is then increasingly being seen as an alternative to or a form of contraception when required (Pestvenidse et al., 2016:87; Palanivelu & Oswal, 2007:832). Within the South African context, where pregnancy often results in

⁹ The names of the CPCC and the tertiary institutions that participated in this research study are withheld for the purpose of honouring and maintaining confidentiality and anonymity. The centre is referred to as the CPCC throughout this research report. Background information regarding the participating centre is provided later in this chapter. The participating tertiary institutions are referred to as Tertiary Institution A, B, C or D.

young women dropping out of school or university, “abortion may be used as a form of emergency contraception” (Mphatswe et al., 2016:153).

1.1.2.4 Factors influencing the decision to terminate the pregnancy

Most women who terminate their pregnancies have different and yet sound reasons for deciding to do so (Mavis et al., 2015:1153; Picavet et al., 2013:328; Tsilo, 2007:2). These reasons differ from one woman to the next and are motivated by external as well as internal factors.

For Barglow and Weinstein (1973, in Franz & Reardon, 1992:162) the decision-making process of whether or not terminate the pregnancy is compounded by intra- and extrapsychic factors (Mavis et al., 2015:1155; Grey, 2014:1202). On an intrapsychic level, poor reality testing, an inability to project the self into the future, massive denial, failure of the executive ego-function, and anxiety complicates the decision-making process. Being inexperienced in making decisions, an unfamiliarity with pregnancy, and peer and parental pressures are labelled as extrapsychic factors straining the decision-making process. A facilitating factor playing an important role during the stage of decision making and the outcomes of a TOP is social support (Grey, 2014:1202; Tsilo, 2007:2).

The decision to terminate a pregnancy is described as difficult, involving several influences, such as the life stage of the conceptus (Mdleleni-Bookholane, 2007:246) and partner/parental support and/or pressure (Mphatswe et al., 2016:153-154; Gatter, Kimport, Foster, Weitz & Upadhyay, 2014:84; Gould, Baker & Foster, 2014:429; Picavet et al., 2013:328). For Adler, David, Major, Roth, Russo and Wyatt (1992:1196-1197) the decision to terminate a pregnancy tends to be a function of the extent to which the pregnancy is wanted or unwanted and the extent to which the woman accepts or rejects TOP as a solution for an unwanted or unplanned pregnancy (Mphatswe et al., 2016:153; Mdleleni-Bookholane 2007:246). A woman's thoughts and feelings towards the TOP, the normative pressures regarding TOPs, and her

beliefs and values regarding having a child further influence her decision whether to opt for a TOP or not (Mavis et al., 2015:1154; Picavet et al., 2013:328; Mdeleleni-Bookholane 2007:246; Adler et al., 1992:1197). In addition to the personal (internal) and situational (external) reasons informing a woman's motivation to seek a TOP (Mdeleleni-Bookholane 2007:246), other influences such as her socio-economic status, age, and marital status have also been found to play a role in the decision-making process (Mavis et al., 2015:1155; Suffla, 1997, in Mdeleleni-Bookholane, 2007:246).

The TOP rate is higher among young people and unmarried women (Mphatswe et al., 2016:155; Steinberg & Russo, 2009:500; Combes, Gaillard, Pellet & Demongeot, 2004:93). Age is an influential factor in deciding whether or not to terminate a pregnancy. This is especially true for young women pursuing tertiary education. A TOP would help in delaying the transition to parenthood and increase their chances of continuing with and completing their studies (Pestvenidse et al., 2016:87; Panday et al., 2009:25; Russo, Horn & Schwartz, 1992:188). The common reasons provided by the literature consulted for why students choose to terminate their pregnancies are as follows:

- **Educational motivations for TOPs:** Research findings indicate as many as 75% of TOP patients younger than 25 (Pestvenidse et al., 2016:87) cited interference with educational opportunities as the primary reason for choosing to terminate a pregnancy (Mphatswe et al., 2016:155; Fergusson, Boden & Horwood, 2007:6). Students fear expulsion from education institutions or an interruption of their education. Having a termination mitigates the educational disadvantage associated with early and/or UPs and several scholars note that TOPs amongst TSs may protect their educational opportunities and allow them greater freedom to pursue educational goals (Mphatswe et al., 2016:155; Pestvenidse et al., 2016:87; Panday et al., 2009:25).
- **Students' economic realities:** Students generally have limited economic resources and reasons for UPs concerning financial constraints include the inability to support a child, unemployment, and general financial problems

(Macleod et al., 2016:1101; Mphatswe et al., 2016:155; Macleod & Tracey, 2009:13; Combes et al., 2004:93).

- **Social condemnation:** UPs are still judged by many as immoral and students often fear being stigmatised, socially marked, or rejected – not only by a current boyfriend, but also future ones. The decision to choose to terminate a pregnancy is seen as a preventative measure so as not to upset their parents and/or partner and/or bring shame and condemnation on their family (Mavis et al., 2015:1154; Macleod & Tracey, 2009:13; Mdleleni-Bookholane, 2007:246-247).
- **Pressure from partner or parents to terminate the pregnancy:** Many students experience lack of support and pressure from their partners or parents to terminate the pregnancy. Such pressure may manifest in the boyfriend denying paternity and/or the boyfriend or the family not supporting the pregnancy (Mavis et al., 2015:1155; Ralph et al., 2014:430; Macleod & Tracey, 2009:13; Bowes & Macleod, 2006:16; Varga, 2003:167).
- **Lack of contraception:** The high prevalence of unintended pregnancies caused by lack of contraceptive use has been referred to earlier in this chapter (see Section 1.1.1.1) and is confirmed by several authors (Mchunu et al., 2012:427; Seutlwadi et al., 2012:46) as a reason for TOPs.

Foster, Higgins, Karasek, Ma and Grossman (2012:149) conducted a study amongst 562 women seeking TOPs at six abortion clinics in the USA with the purpose of exploring the reasons for and attitudes toward unprotected intercourse, knowledge of the risk of conception, and willingness to engage in unprotected intercourse in the future. The results of their survey established “an average of 18 acts of unprotected intercourse leading up to conception” per individual. The most commonly reported reasons for unprotected intercourse were thinking one could not get pregnant (42%), difficulties procuring a contraceptive method (40%), and not planning to have sex (38%). When asked

about attitudes toward unprotected intercourse, 48% of the participants reported that unprotected intercourse feels better or more natural, 36% said it is acceptable to have unprotected intercourse occasionally or at certain times of the month, and 28% cited partner or relationship benefits as a reason to engage in this form of intercourse. In addition, 23% of the participants said they were somewhat or extremely likely to engage in unprotected intercourse in the next three months (Foster et al., 2012:154). The above-mentioned authors consequently confirm the prevalence of risk-taking behaviour and the underestimation of the risk of conception as contributing to the decision to terminate an unintended pregnancy.

A research project conducted by Oosthuysen and Mfomande (2008:24) about the perceptions of female students at a tertiary institution in Pretoria, South Africa, regarding their UPs established that between 68% and 72% of the 20 participants who fell pregnant and terminated their pregnancies indicated that it was because of non-contraceptive use, contraceptive misuse, or incorrect use of contraceptives. Whilst most adolescent pregnancies in South Africa are unwanted, it seems that more than 50% of the young women in this situation did little or nothing to prevent an UP (Macleod et al., 2016:1102).

- **Being a victim of incest or rape:** Cross-cultural data from national rape crisis centres in South Africa reveal that a large percentage of rape and sexual abuse is perpetrated against not only young girls, but also against adolescents and young women (Mphatswe et al., 2016:155; Pestvenidse et al., 2016:88). An UP as a result of incest or rape is often dealt with by means of TOP.

For many students confronted with a crisis pregnancy, TOP seems to be the easiest way to deal with the problem. The termination of a pregnancy is often seen as a secret, quick, and affordable procedure. When an UP is traumatic, an opportunity to quickly and secretly become “un-pregnant” can be very appealing (Gomez-Scott & Cooney, 2014:651). Unfortunately, most students who decide to terminate their

pregnancy seem to be ill informed or not informed at all regarding the procedure and they seldom walk away from the experience untouched, even though they move forward with their lives. It has been found that even though women choose to terminate their pregnancies, they are not always prepared for the possible psychosocial implications (Picavet et al., 2013:328; Sekudu, 2001:32). Women could experience emotional trauma, regret the termination, or blame their decision on circumstances and a lack of information (Macleod et al., 2016:1102; Lince-Deroche et al., 2015:340; Macleod & Tracey, 2009:13). It is furthermore stated that women's responses to TOPs could be similar to those of the grief process (Harries et al., 2014:16; Goodwin & Ogden, 2007:232).

1.1.2.5 Experiences and consequences of a TOP

The decision to terminate a pregnancy is not a frivolous one. No woman sets out to create and then terminate a possible life; but, over the centuries, millions of women have terminated their pregnancies and millions more will continue to terminate unwanted pregnancies regardless of social, religious, or legislative opinion (Leask, 2015:179).

While many women generally experience a feeling of relief after the termination of their pregnancy, aspects of the experience that they had never anticipated understandably upset them (Rocca, Kimport, Roberts, Gould, Neuhaus & Foster, 2015; Macleod & Tracey, 2009:12; De Puy & Dovitch, 1997:14). Many are distressed and unaware of the ways in which their choice has changed their lives and, sometimes, the lives of those around them. Many have been unwilling to speak of their choice in a world that is openly conflicted about TOPs. Many are wracked with religious guilt and fear that they have killed an unborn child. These reactions, as well as unresolved feelings of guilt, shame, and sadness, are not felt on the day of the termination, but may arise months, often years, after the termination of the pregnancy (Bradshaw & Slade, 2013:935; Charles, Polis, Sridhara & Blum, 2008:436; Kero, Högberg & Lalos, 2004:2559).

The impact a TOP has on the psychological life of the woman who makes this choice usually goes unheard. There is no cultural acknowledgement that she may have struggled over her decision, or felt bereaved, or that the event may have left her with pain (Trybulski, 2006:684). Thus, TOP remains a significant personal experience that is not publicly recognised, socially sanctioned, or frankly shared in the same way a divorce, the death of a loved one, or a miscarriage might be (Bradshaw & Slade, 2013:932).

In explaining the psychological consequences of a TOP, Miller (1992:67) presents what he refers to as the “Theoretical Model of the Psychological Antecedents of Abortion” (Miller, 1992:79), in which an unwanted pregnancy leads to an induced TOP, which in turn results in some psychological consequences (Mdleleni-Bookholane, 2007:247; Miller, 1992:79). Miller describes, within this model, several models that he considers as alternatives of the basic model (Mdleleni-Bookholane, 2007:248). According to Miller (1992:79), the psychological consequences of a TOP can be placed into two categories, namely short-term and long-term psychological consequences (Mdleleni-Bookholane, 2007:248).

Short-term consequences last from a few days to a few weeks, and these can be understood by looking at the crisis and biological models. In the crisis model, the experience of an UP (normally perceived as a crisis) results in feelings of anxiety that subsequently lead to induced TOP, which in turn leads to some relief and a reduction of anxiety (crisis resolution) (Mdleleni-Bookholane, 2007:248). In the biological model, the interruption of a pregnancy produces a sudden reduction in certain circulating hormones, which has the potential to temporarily alter a woman’s state of mind (Mdleleni-Bookholane, 2007:248). This state of mind plays a role in what is usually described as the “post-abortion/termination blues” (Lemkau, 1988 in Miller, 1992:80).

Long-term consequences last for months or years and should be understood, according to Miller (1992:81-83), by means of the stress, norm violation, loss, decision, and learning models (Mdleleni-Bookholane, 2007:249).

In the **stress model**, the focus is on the belief and perception that an unwanted pregnancy produces stress (Mdleleni-Bookholane, 2007:248), which, together with induced TOP, creates distress, with the latter including several negative effects and other psychological conditions. Miller (1992:81) states in this regard that aspects such as self-esteem, coping mechanisms and support (or the lack thereof) are risk factors that could play a role in the experience of pre-termination stress and post-termination distress.

The central idea within the **norm violation model** is that that social norms, normally pro-natal and anti-abortion (Mdleleni-Bookholane, 2007:249), exist in most communities and are often internalised by individuals (Miller, 1992:81). These norms have been found to lead to women experiencing conflicting emotions about the TOP as well as feelings of guilt, shame, or fear of disapproval if she actually goes through with the TOP (Mdleleni-Bookholane, 2007:249).

The **loss model** is based on the principle that women with an unwanted pregnancy experience varying degrees of desire (Mdleleni-Bookholane, 2007:249) to continue with the pregnancy and bear the child. A strong desire tends to result in the TOP being preceded by uncertainty and the experience of feelings of loss, grief, anger and depression following the TOP (Miller, 1992:82). Furthermore, coercion, or pressure from significant others to consider a termination, for example where the pregnancy is wanted but threatened by maternal health problems or a genetic defect in the foetus (Mdleleni-Bookholane, 2007:249), could result in the woman experiencing pre-termination ambivalence and post-termination feelings of loss (Miller, 1992:82).

The **decision model** concerns itself with the decision-making process prior to the TOP (Mdleleni-Bookholane, 2007:250) and the negative feelings following the

decision (Miller 1992:83). Situational constraints, such as conflict with or pressure from significant others, and unanticipated developments following the TOP (Mdleleni-Bookholane, 2007:250) resulting in the experience of feelings of regret and guilt, are seen as important determinants in the decision-making process (Miller 1992:83).

The **learning model** is based on the assumption that women learn and change their behaviour (Mdleleni-Bookholane, 2007:250) following an unplanned and unwanted pregnancy and/or induced TOP experience (Miller 1992:84). These changes may be negative, such as fear and avoidance of sex, or it may be positive, such as improved contraceptive practice (Mdleleni-Bookholane, 2007:251). The changes may furthermore lead to relationship changes with the latter being ascribed to the negative effects resulting from the experience, as well as to the self-awareness and understanding that the woman may gain while addressing possible relationship challenges and changes problems (Miller 1992:84).

Miller's (1992:930) explanation of the psychological consequences of a TOP led to the development of the concept "post-abortion stress" (referred to as PAS) (Curley & Johnston 2013:283). In this context, the termination of an unintended pregnancy is regarded as a significant and prevalent transition in the woman's life course resulting in a type of post-traumatic stress disorder (PTSD) (Rocca et al., 2015; Bradshaw & Slade 2013:934; Lawlor, 1996, in Tsilo 2007:8; Speckhard & Rue 1992:106).

In their study focusing on the characteristics and severity of psychological distress after abortion among university students, Curley and Johnston (2013:284) found that 89 of their 151 student participants who experienced a TOP "reported symptoms of PTSD and grief lasting on average 3 years". The participants for this study were recruited from the student populations of the McGill and Concordia Universities in Montreal, Canada, as well as from the University of Vermont, USA. They concluded that the distress that the students experienced as a result of their TOPs comprised moderate to severe symptoms of psychological trauma (Curley & Johnston, 2013:288).

Other research studies conducted with the purpose of determining women's responses to TOPs established that the post-termination sequelae include depression, feelings of regret, anxiety, and guilt are experienced by women who have terminated a pregnancy as long as 15 years ago (Rocca et al., 2015; Bradshaw & Slade, 2013:930; Curley & Johnston, 2013:288; Oosthuysen & Mfomande, 2008:25; Trybulski, 2006:683). Difficulties with subsequent pregnancies, life milestones (such as graduating from college or marriage), and mundane occurrences involving friends' children were also identified as common triggers for recurring thoughts about past terminations. It was also reported that young women who choose to terminate their unintended pregnancies are five times more likely to seek help for psychological and emotional problems afterwards than those women who carried their pregnancies to term (Harries et al., 2014:16; Bradshaw & Slade, 2013:936).

In summary: Post-abortion/termination stress includes psychological disturbances, such as depression, tearfulness, indecision, disturbed sleep, nightmares, flashbacks, inappropriate anger, self-punishment, painful thoughts and feelings on significant dates, isolation, suicidal ideation, and suicide (Bradshaw & Slade, 2013:934). In addition, behavioural disturbances because of a TOP may include the following: avoiding babies, children and pregnant women; relationship problems and withdrawal; promiscuity; sexual coldness and avoidance of intimacy; physical tension; or the desire to have another baby (Bradshaw & Slade, 2013:934).

Healing after a TOP is a "unique challenge" (De Puy & Dovitch, 1997:14), because the emotions a woman experiences are the result of a choice she made (Mavis et al., 2015:1153; Bradshaw & Slade, 2013:936). Paradoxically, her healing journey requires yet another choice – a "healing choice" (De Puy & Dovitch, 1997:14). This healing journey requires that the woman–

- reflect upon the circumstances and reasons for her decision;
- explore the emotions that lead to and resulted from her TOP;

- examine relevant issues arising from both her family of origin and the culture in which she was raised; and
- realise how the overall experience may have impacted her life then and now by recognising what she lost and what she has gained.

The preceding discussion of the aspects related to UPs and TOPs relevant to the focus of this research study served as an introduction to the study, or as Creswell (1994:21) puts it, to “provide a useful backdrop for the problem”. This section is herewith concluded. I will now introduce the problem formulation and the rationale for the study, as well as the theoretical framework for the study.

1.2 PROBLEM FORMULATION

Forming part of and evolving from the introduction and background to a study, is stating the problem pointing to the need for the research undertaking. For Creswell (2016:88), a research problem is something that needs to be addressed and solved, and he advises qualitative researchers to think about research problems in terms of “real-life” and “literature” related problems, as the problem statement resulting from such a problem formulation should be a combination of both.

When focusing on the aspect of “real-life” problems, the increase in UPs and TOPs amongst TSs could be regarded as “real-life” problems. This increase in the said phenomenon is not only reported in the literature consulted (Hodes, 2016:79; Curley & Johnston, 2013:283; Mchunu et al., 2012:432; Naidoo & Kasiram, 2006:341), but was also observed at my place of employment¹⁰, where I, in my capacity as a social worker, provide psychosocial services to TSs.

¹⁰ I am employed as a social worker at an institution of higher education in Pretoria (Tshwane), South Africa. Permission and ethical clearance were obtained from the institutional Research Ethics Committee (at my place of employment) to conduct this research study. A discussion of this procedure is presented later in this research report (please refer to Chapter Three in this regard). The name of the institution, however, is withheld to honour and maintain anonymity and confidentiality and the institution will consequently be referred to as Tertiary Institution D.

The increase in this phenomenon, indicated in Table 1.1, made me aware of the need to support TSs that find themselves in the quagmire of an UP and/or TOP. This prompted me to facilitate a cooperative agreement with a certain CPCC¹¹ in Pretoria (Tshwane), South Africa, with the aim to establish a satellite counselling centre on one of the campuses of the tertiary institution where I am employed. This satellite counselling centre, staffed by trained, supervised volunteer counsellors from said CPCC, was established in March 2005 with the purpose of supporting and enhancing the quality of the current support services with reference to counselling and health services offered to students registered at the mentioned tertiary institution. The significant increase in the number of UPs, TOPs, and instances of PAS gleaned from students requesting counselling for these phenomena is accordingly presented in Table 1.1.

Table 1.1: The prevalence of and increase in UPs, TOPs, and PAS at Tertiary Institution D from 2005 – 2016

YEAR	SUPPORT SERVICES AT TERTIARY INSTITUTION D		
	Student Counselling	Campus Health Services	CPCC Satellite Counselling Centre
	<i>Students requesting counselling for UP, TOP, or PAS</i>	<i>Students testing positive for pregnancy</i>	<i>Students referred by Student Counselling or Campus Health Services for counselling regarding UP, TOP, and PAS</i>
April 2005 – November 2007	31 (18 UPs and pre-termination counselling & 13 PAS)	169	279 (124 UPs and pre-termination counselling & 155 PAS)

¹¹ The name of the CPCC, situated in Pretoria (Tshwane), is withheld to honour and maintain anonymity and confidentiality. This centre is one of a few in South Africa and is well known for the support that they render to TSs from various higher education institutions in Pretoria (Tshwane). It is registered as an NGO and was established 28 years ago with the purpose of providing care, support, and counselling for women with UPs. Trained and supervised volunteer counsellors staff the centre and provide free and confidential services, which include pregnancy tests and crisis pregnancy counselling. The latter is done in person and/or telephonically and consists of, amongst others, the provision of detailed information regarding UP options/decisions, namely parenting, adoption, or TOP. In addition, information is passed on about the development of a baby and STIs. Practical advice on caring for a baby is offered and, in the case of adoption or TOP, appropriate referrals are made. Counselling for pregnancy loss through TOP, miscarriage, or stillbirth is also offered.

January 2008 – November 2010	104 (81 UPs and pre-termination counselling & 23 PAS)	268	539 (221 UPs and pre-termination counselling & 318 PAS)
January 2011 – November 2013	236 (213 UPs and pre-termination counselling & 23 PAS)	238	
January 2014 – November 2016	221 (185 UPs and pre-termination counselling & 36 PAS)	241	
TOTAL	592	916	818

Apart from the fact that counselling and support services at the satellite centre, depicted in the table above, were offered to the TSs at Tertiary Institution D three days per week, the Director of the CPCC¹² confirmed that many students also received, and were still receiving, counselling for UPs, TOPs, and PAS at their off-campus offices. Her estimation was that out of the approximately 600 women they counsel annually, a third of these women were students from tertiary institutions in Pretoria. These statistics, however, are not a true reflection of the actual state of affairs, as many students are hesitant to report their status and supply false information in this regard. Her concern about the prevalence of and increase in the mentioned phenomena was expressed in the following way: “...This is a major problem that needs to be addressed; as a matter of utmost urgency... guidance regarding specialised intervention is required” (The Director, CPCC, 2014 & 2009).

Staff shortages and financial constraints unfortunately necessitated the closure of the mentioned satellite counselling centre on the campus of Tertiary Institution D in December 2010. Since then an effective referral system between the mentioned CPCC, Tertiary Institution D, and the counselling and healthcare units of various other tertiary institutions in and around Pretoria (Tshwane) has been established with good working relationships existing amongst them¹³.

¹² The name of the Director is withheld in order to protect her identity. However, I kept and maintained a comprehensive record of all communication in this regard for perusal. These records are stored in a safe place and will be destroyed five years after completion of this study.

¹³ A discussion of the cooperation between the CPCC and Tertiary Institution D is presented later in this research report. Please refer to Chapter Three for a discussion thereof.

The prevalence of and increase in UPs, TOPs, and PAS amongst TSs, as noticed by me and confirmed in the literature referred to, were also confirmed by service providers¹⁴ (SPs) at other tertiary institutions¹⁵ in Gauteng. I made contact with various practitioners and role players in this regard. The following feedback from practice was received, confirming the problem, as well as a need for directives and practice guidelines for SPs to support these students:

“Our students are not taking care of themselves... I see a lot of trauma related to UPs and TOPs. I don’t think our efforts and interventions to address this problem are effective” (Healthcare Professional, Tertiary Institution A, Telephone interview, 2009).

“There has been a significant increase in UPs amongst the students at our institution. The majority of students at our institution with an UP choose to terminate the pregnancy, purely because it seems to be the easiest way to deal with the problem. Having an abortion enables the student to continue with her tertiary studies” (Healthcare Professional, Tertiary Institution B, 2009).

“This phenomenon is a reality that requires effective intervention” (Student Counsellor, Tertiary Institution B, 2009).

“We have seen a very significant increase in UPs and abortions amongst our students, especially over the last nine months. This is a big concern for us, as it affects the academic performance and wellbeing of our students. I believe that a lack of knowledge and skills amongst students attribute to this phenomena and I

¹⁴ In the context of this study, the term ‘service provider(s)’ is used as an inclusive term that refers to professional practitioners rendering professional support services to TSs. Please refer to Section 1.5 of this chapter for a detailed clarification of this concept, as well as a clarification of related concepts (namely the concepts ‘support’ and ‘support services’, which are also presented in Section 1.5). The names of the SPs who participated in this study are withheld in order to protect their identities.

¹⁵ The tertiary institutions were, for the purposes of ensuring and maintaining anonymity and confidentiality, coded and are referred to as Tertiary Institution A, B, C and D. Comprehensive contact registers and records of communication/interaction with the different SPs, tertiary institutions, and other relevant organisations (the CPCC) were however kept. These records are stored in a safe place and will be destroyed five years after completion of this study.

furthermore believe that there is a serious lack of and need for effective support and programmes at tertiary level to address this problem” (Student Counsellor, Tertiary Institution C, 2009).

“We are very worried about the increase in unintended pregnancies amongst our students. We try and assist and accommodate them but sometimes I wonder if our efforts are making any difference” (Student Counsellor, Tertiary Institution D, 2009).

In addition to Creswell’s (2016:88) suggestion that “real-life” problems should inform the need for an investigation, problems in the literature should also serve as justification for being chosen for research. According to Creswell (2016:88), literature-related problems are expressed along the following lines: there is a “need for more literature”, it is noticed that the “the topic has been understudied”, or that “there is little research on the topic”. Maree (2016:29) also points out that the “stillness”, “inconsistency”, or “challenge” in the literature can prompt the investigation of a specific topic.

This “stillness” in the literature on the aspect of practice guidelines for psychosocial support based on and informed by TSs’ experiences and needs related to UPs and TOPs will now become the focus of the discussion.

As far as my place of employment is concerned, there are no formal policy or practice guidelines to address the problem of UPs. The only stipulation referring to pregnant students is found in the institutional rules and regulations¹⁶, stating that pregnant students are allowed, at their own risk, to reside in institutional accommodation (a

¹⁶ The Mentioned Rules and Regulations are included in the institutional Prospectus of Tertiary Institution D. The Prospectus is updated and published annually and every registered student is provided with a copy thereof, as it is expected that students acquaint themselves with all the rules and regulations. The latter is based on the decisions of the Senate and the Council of the institution by virtue of the authority vested in them, in terms of the provisions of the Higher Education Amendment Act 23 of 2001 (South Africa, 2001) and the requirements set for national education programmes at tertiary institutions.

residence) until the fifth month of pregnancy. Whilst this stipulation is on paper, in reality, some pregnant students have in the past approached university officials and lecturers with requests to utilise university accommodation for the duration of their pregnancy, for “maternity leave”, or special arrangements to accommodate them with alternative submission dates for submitting assignments/projects and sitting for tests/examinations. This, however, is regarded as the exception and not the rule.

Looking at the broader Higher Education Landscape, the Minister of Education, Ms Naledi Pandor, at the Annual National Conference of the Higher Education Learning and Teaching Association of South Africa (HELTASA) in November 2006, made it very clear that maternity leave for scholars and students will not be considered by the DoE (HELTASA, 2006). The Department’s approach to UPs amongst scholars and students is underpinned by the Constitution of the Republic of South Africa (1996), which forbids discrimination (such as punishment or suspension) against learners based on pregnancy (Basic Education Rights Handbook, 2016). The Department’s policy regarding unplanned pregnancies is set out in the Draft National Policy on the Prevention and Management of Learner Pregnancy (Parliamentary Monitoring Group, 2018) and the Measures for the Prevention and Management of Learner Pregnancy (DoE, 2007). According to these documents, learner pregnancy is “discouraged” and learners are encouraged to abstain from risky sexual behaviour. Both these documents (DoE, 2007 & 2018) provide a framework for educating learners about their rights and responsibilities in relation to pregnancy. In addition, the documents highlight the importance of sex education and prevention programmes in addressing this problem. Furthermore, these documents provide procedures and guidelines to be followed in cases where learners do get pregnant. One of the guidelines is that a learner may request or be required to take a leave of absence from the educational institution in order to address pre and post-natal health concerns, as well as to care for the new-born baby (DoE, 2007:5).

In conducting a literature search on the state of knowledge on the proposed topic for investigation, with specific reference to practice guidelines for psychosocial support

informed by and based on TSs' experiences and needs in relation to UPs and TOPs, within the ambit of social work, locally and internationally, I noticed a lacuna in the body of knowledge available. The search of the literature did not deliver any results in terms of practice guidelines, or programmes and interventions from the ambit of social work, or any other related disciplines directed at supporting students with UPs and/or who have terminated a pregnancy, where such intervention is informed by the students' specific experiences and needs in this regard. Instead, the literature search, focusing specifically on research publications of the last 10 years, pointed me to a plethora of information which included the following: information on the factors contributing to the phenomenon, the consequences thereof, as well as the perceptions and attitudes of students in this regard (Wise et al., 2017:9; Bongaarts & Casterline, 2013:154; Seutlwadi et al., 2012:45-46; Patel & Johns, 2009:496; Patel & Kooverjee, 2009:553; Abiodun & Balogun, 2009:146; Naidoo & Kasiram, 2006:346).

There is pressure on tertiary institutions worldwide to address high student dropout rates and focus on increasing their throughput rates (Yorke, 1991:1 in Nel, 2008:66). Concerns about the poor retention rates of South African students (Murray, 2014:2; Nel, 2008:66) and the dire consequences thereof is expressed in the following statement in the Draft National Plan for Higher Education (Ministry of Education, 2001:21):

These poor graduation and retention rates and high drop-out rates are unacceptable and represent a huge waste of resources, both financial and human. For example, a student dropout rate of 20 per cent implies that about 1.3 million in government subsidies is spent each year on students who do not complete their study programmes. These funds would go a long way not only in financing the expansion of the higher education system, but also in providing the much needed funds for addressing the inequities of the past.

UPs have been cited as one of the factors contributing to the problem of high student dropout rates (Matsolo et al., 2016; Gama, 2008:26; Naidoo & Kasiram, 2006:341). Calls are consequently made to investigate the reasons for this phenomenon and to develop strategies to address this problem (Calvert et al., 2013; Macleod & Tracey, 2010:20-21; Mahlangu & Silaule, 2009:6; Naidoo & Kasiram, 2006:341).

From this introductory account and the nature of the knowledge on the topic decided upon for investigation, the **research problem** can in summary be delimited as follows:

The prevalence of and increase in UPs and TOPs is a real-life problem, with detrimental effects on the students, their significant others, and tertiary institutions. In addition, there is a stillness in the literature with reference to practice guidelines for psychosocial support from the ambit of social work to assist SPs in their service delivery to TSs presenting with an UP and/or TOP. The development of such guidelines should be informed by and based on the experiences, needs, and suggestions of TSs who have had an UP and/or TOP, as well as the perceptions and suggestions of SPs rendering psychosocial support services to said students.

1.3 THE RATIONALE FOR THE STUDY

Referring to the aspect of writing the rationale for a research study, Vinthal and Jansen (in Maree, 2016:30) suggest that researchers need to explain how they developed an interest, also referred to as “a critical interest” (Babbie & Mouton, 2010:11; Babbie & Mouton, 2007:14), in a specific topic. Furthermore, an explanation must be given for why the research is worth conducting. Bless, Higson-Smith and Kagee (2006:6) add to this by emphasising that the motivation for a research study should be related to a practical problem, involve a wide population, and should fill a knowledge or research gap.

Departing from these introductory remarks, my reason for embarking on this research journey is consequently provided. My interest in and passion for this study was sparked by the rise in the number of students requesting, reporting, and being referred for counselling services in connection with UPs, TOPs, and PAS at my place of employment. I developed a personal interest in and concern about the problem of UPs and the TOPs amongst TSs. In turning to literature to read up more about this topic, I came to the conclusion that this was not only a real-life problem at the tertiary

institution where I am employed, but a dilemma triggering national and international concern (Bongaarts & Casterline, 2013:154; Mchunu et al., 2012:426). Unintended pregnancy has become one of the contributors towards the dropout rate of female students at tertiary institutions (Matsolo et al., 2016; Macleod & Tracey, 2010:18; Gama, 2008:24; Naidoo & Kasiram, 2006:341), resulting in financial losses incurred by the institution, the student, and her family (Wise et al., 2017:8; Calvert et al., 2013). The emotional impact of the crisis pregnancy, which often ends in a TOP, could in turn result in the student experiencing post-abortion/termination stress symptoms (Harries et al., 2014:16; Bradshaw & Slade, 2013:933; Curley & Johnston, 2013:281). These symptoms could have a detrimental effect on the student's wellbeing and relationships, and ultimately her academic performance.

Immersing myself into this topic, which has since become a critical interest, and looking at the literature from the disciplines of social work, nursing, and psychology, for suggestions, practice guidelines, strategies, or programmes to counsel TSs reporting for support and assistance with UPs, TOPs, and PAS, no tailor-made guidelines and/or programmes directed at this target group could be found. This state of affairs motivated me to embark on this endeavour with the aim of proffering practice guidelines for psychosocial support, to assist SPs in their service delivery to TSs requiring support¹⁷ in this regard. The guidelines will be based on and informed by the experiences and needs of TSs presenting with an UP and/or TOP, as well as the perceptions of SPs rendering support to said students.

It is anticipated that these practice guidelines for psychosocial support (based on and informed by both the experiences and needs of students, and the perceptions of SPs), would furnish SPs with knowledge, skills, and strategies that would empower them to respond effectively to the needs of students presenting with problems related

¹⁷ This concept, in the context of this research study, refers to and includes any intervention (therapeutic/psychological support, such as counselling, or non-therapeutic support, such as the provision of social resources which could include information, education, or practical assistance such as a referral) that aims to increase the coping skills of a person confronted with the challenges and stressors associated with an UP, TOP, or PAS (Tol, Barbui, Galappatti, Silove, Betancourt, Souza, Golaz & Van Ommeren, 2011). A detailed clarification of this concept is presented in Section 1.5.10 of this chapter.

to UPs and TOPs. It is my conviction that the practice guidelines would become a contributor to address the prevalence of and increase in UPs and TOPs among TSs. It would work towards increasing student success rates and universities' throughput rates, as well as minimising the financial losses experienced by all parties because of UPs and TOPs.

It is envisaged that these practice guidelines for psychosocial support would make a contribution to the knowledge base and field of social work with specific reference to addressing reproductive health issues, increasing student success rates, fulfilling career aspirations for students, and achieving universities' social mandate from a multi-sectoral angle.

1.4 THE THEORETICAL FRAMEWORK ADOPTED FOR THE STUDY

The importance of the utilisation of a theoretical framework in any research process, irrespective of the approach applied (qualitative, quantitative, or mixed methods approach), is emphasised by several authors (Maxwell, 2013:48; Neuman, 2012:27; Silverman, 2010:141; Creswell, 2009:69). In underscoring the significance and role of theory within qualitative research, Silverman (2010:141) writes: "Theory... should be neither a status symbol nor an optional extra in a research study. Without theory, research is impossibly narrow. Without research, theory is mere armchair contemplation."

Within the context of qualitative research, the theoretical framework serves as a foundation on which the researcher builds a study (Grant & Osanloo, 2014:13). It clarifies the structure of and vision for the study – it serves as a "blueprint" (Grant & Osanloo 2014:13). The theoretical framework guides the research process by relying on a formal theory¹⁸ that "undergirds your thinking with regard to how you understand

¹⁸ Although many social science research projects fit into the rubric of being rooted in a specific theory, it is recognised that some researchers do not rely on an existing theory. They "craft their own blueprint for a new theory to be developed a posteriori as a result of their research endeavors" (Grant & Osanloo, 2014:16; Swanson & Chermack, 2013:30).

and plan to research your topic, as well as the concepts and definitions from that theory that are relevant to your topic” (Grant & Osanloo, 2014:13).

A *theoretical framework* is differentiated from a *conceptual framework*, in that the latter is viewed as the researcher’s understanding of how the research problem will best be explored, the direction the research will have to take, as well as the relationship between the different variables in the study. The conceptual framework is the system of concepts, assumptions, and beliefs that support, guide, and explain the research plan, as well as the natural progression of the phenomenon being studied (Grant & Osanloo, 2014:16-17; Swanson & Chermack, 2013:29). The theoretical framework, on the other hand, is derived from an existing theory (or theories) that has already been examined, evaluated, and validated by others and thus considered “a generally acceptable theory” (Grant & Osanloo, 2014:16). It is proposed in this regard that the theoretical framework serves the purpose of being the researcher’s “lens with which he/she views the world” (Creswell, 2009:49; Merriam, 2009:22), or the method researchers use to “extract meaning, understand processes and, in turn, generate theory itself” (Kramer-Kile, 2012:29). Kramer-Kile’s (2012:29) advice to qualitative nurse researchers to be knowledgeable of theoretical perspectives both inside and outside of the nursing discipline also rings true for the social worker as researcher, as the theoretical perspectives coined in other disciplines may offer a richer understanding and further extend and generate discipline-specific knowledge. It is therefore important for the researcher to decide on a theoretical framework and to apply the theoretical constructs inherent in it (Grant & Osanloo, 2014:16; Merriam, 2009:21).

In explaining the concept “theory”, Maxwell (2013:48) sees it as “a structure based on a set of interrelated concepts and ideas intended to capture or model something about the world.” Metaphorically speaking, he views the use of an existing theory in qualitative research to serve as a “coat closet”, with concepts of the existing theory thus serving as the “coat hooks” in the coat closet in that they provide places to “hang” the data, showing their relationship to other data (Maxwell, 2013:49). Hence,

the utilisation of an existing theory enable researchers to make sense of what they see, and by looking at specific fragments of data which might seem irrelevant or unconnected to one another or by positioning the answers to the research questions into a fitting theory” (Maxwell, 2013:49). It is concurred that a useful theory can be seen as an unfolding story about a specific phenomenon, what one thinks is happening and why it is happening, with this process resulting in an increased understanding of and new insight in the phenomenon (Maxwell, 2013:49; Neuman, 2012:26).

Various scholars highlight the importance of flexibility and avoidance of too much rigidity in terms of the application of a specific theoretical framework when exploring a phenomenon from a qualitative perspective, as this could strengthen or weaken the study (Maxwell, 2013:53; Swanson & Chermack, 2013:14). Excessive rigidity in the application of a particular theoretical framework could result in the researcher forcing questions or research methods (Maxwell, 2013:53). It is deduced that good theory in the social sciences, by virtue of its applicative nature, is of value because it fulfils the purpose of explaining the meaning, nature, and challenges associated with the (often experienced, but unexplained) phenomenon being studied. This enables one to “use the knowledge and understanding to act in more informed and effective ways” (Swanson & Cherrmack, 2013:14). In summary, Thomas (2017:99) asserts that a theory can serve as tool, used for the purpose of helping to explain what is currently being researched.

1.4.1 Schlossberg’s Model for analysing human adaptation to transition

Against the aforementioned introduction of the concept and function of a theoretical framework within qualitative research, I will now introduce Schlossberg’s Model for analysing human adaptation to transition (Schlossberg, 1991:5), also referred to as the Transition Process Model (Anderson, Goodman & Schlossberg 2012; Schlossberg 1981; Schlossberg 2011) adopted as the theoretical framework for this study.

Schlossberg, a contributor to the field of counselling and sociology since the 1950s, developed her Transition Theory by collaborating with several other authors and documenting her findings. She earned her Doctor of Education degree in Counselling at the Teachers College of Columbia University and served as a faculty member of several universities. She has extensive experience in working with young adults in the field of student development and support in higher education, and is seen as an expert in the areas of adult transitions, retirement, career development, adults as learners, and intergenerational relationships (Transitions Through Life, n.d.). Her research for her Transition Theory, titled *A Model for analyzing human adaptation to transition* (Schlossberg, 1981:2-18) was first published in a periodical in 1981, after which she published a book called *Counseling Adults in Transition* in 1984 (Anderson et al., 2012; Schlossberg, 1984). Several other publications followed, of which *Improving Higher Education Environments for Adults* (Schlossberg, Lynch & Chickering, 1989) and *Getting the Most Out of College* (Chickering & Schlossberg, 1995) are seen as particularly significant for SPs rendering services to TSs, as they address the individual, relationship, and work transitions that this specific client system group experiences.

The Transitional Model has its origins in crisis theory (Moos & Tsu, 1976, in Schlossberg, 1981:6), which asserts that people generally operate in consistent patterns or in equilibrium with their environment, solving problems with habitual mechanisms and reactions. When the latter fails, tension and feelings of discomfort arise with the individual experiencing emotions such as anxiety, fear, guilt, shame, or helplessness. A crisis is thus essentially seen as a disturbance of the equilibrium, or an event or non-event, described as an “upset in a steady state”, which also signifies a transition/turning point (Moos & Tsu, 1976, in Schlossberg, 1981:6). This definition resonates with the more recent definition of Turner (2011:134), who describes a crisis as a time of intense difficulty involving an impending change. According to Turner, a crisis signifies a turning point that requires making an important decision. Squire (in Parker & Schotter, 2015:33) adds to this description by defining a crisis as an emotionally stressful event or change in a person’s life.

For many, if not most TSs, the suspicion and/or confirmation of an UP and/or the experience of a TOP (as events) signifies a transition or a turning point that has the potential to drastically alter envisaged personal and career goals, as well as established social identity patterns¹⁹ (Daley, 2012:38; Van Breda, 2011:3; 'Lanre, 2010:197). The occurrence of an unplanned pregnancy or the experience of a TOP is regarded as a "crisis", with several scholars describing the phenomenon as a "major life event stressor" and a "highly traumatic event", disrupting the equilibrium of the student's academic, social, relational, and family life (Tabane & Mmapheko, 2015:2; Adams & Williams, 2011:1879; Daley, 2012:38; Skinner et al., 2009:52; Sodi, 2009:19). During this period of disequilibrium action is required as the student has to work out ways of handling the crisis and, as Weiss (1976, in Schlossberg 1981:6) states, this involves a summoning of the individual's resources in order to either arrest the crisis and return to the pre-crisis stage, or to embark on re-organisational change. For the TS confronted with the crisis of an UP, restoring equilibrium implies, amongst others, the acknowledgement and understanding that she is in transition, with the latter referring to an interim phase for adjustment to change.

According to Schlossberg (1981:6), the transition phase is a "period marked by changes in relationships, routines, assumptions and roles", rich in feelings and emotional reactions (Mnyango, 2015:17; Schlossberg 2011:159; cf. Evans, Forney & Guido-Dibrito, 1998:111). This phase is characterised by efforts to not only to take stock of and manage established sources of support, but also to identify and enlist new sources of support to address the transition and the adaptation thereto (Schlossberg, 1981:6).

¹⁹ Social identity refers to a person's sense of who they are based on their group membership, with the latter being an important source of pride and self-esteem (Jenkins, 2014:39). Social Identity Theory originated from British social psychologists Henri Tajfel and John Turner in 1979. They proposed that an individual does not just have a personal selfhood, but multiple selves and identities associated with their affiliated groups. The mentioned authors furthermore purport that people might act differently in varying social contexts according to the groups they belong to (Tajfel & Turner, 1979 in Jost & Sidanius, 2004:276).

It is furthermore emphasised that the outcome of a transition may be positive or negative. Moos and Tsu (in Schlossberg, 1981:6) state in this regard that a transition may either provide “an opportunity for psychological growth or a danger of psychological deterioration”. The ambivalence that is common to many transitions is influenced by several transition characteristics (elaborated on later in this section) that affect adaptation (Schlossberg, 1981:6) and it is perpetuated that a transition is only a transition if it is considered as such by the individual living through it (Schlossberg, 1981:7). Adaptation to transition is therefore described as “a process during which an individual moves from being totally preoccupied with the transition to integrating the transition into his or her life” (Schlossberg, 1981:7).

In the context of this study, application of the concept of adaptation implies that the experience of an UP or TOP signifies a crisis, declaring a transition or a turning point. Dealing with this crisis and the integration thereof in one’s life relates to the adaptation to the transition (Tabane & Mmapheko, 2015:3; Daley, 2012:40; Van Breda, 2011:5). This includes, but is not limited to, the following:

- Addressing the high levels of stress, fear, and uncertainty that accompanies an UP and/or TOP.
- Exploration of individual variables that might influence the decision regarding the UP.
- Psychological adjustment in and following the decision-making process.
- Offering social, medical, practical, and therapeutic support in and following the decision-making process.

Healthy adjustment to an UP or TOP, according to Grey (2014:1201) and Sereno, Leal and Maroco (2013:145), therefore implies, amongst others, the following: That –

- support has been rendered in terms of the decision-making process;
- the intense emotions (such as stress, fear, anxiety, guilt, shame, sadness, etc.) that generally accompany such a crisis have been effectively dealt with; and
- a (new) sense of self-esteem and hope has been restored.

In latching on to the earlier reference to the characteristics that seem to influence the process of adaptation to transition (Schlossberg, 1981:8), a presentation of the Transitional Model is presented in Figure 1.1. This is followed by a discussion thereof.

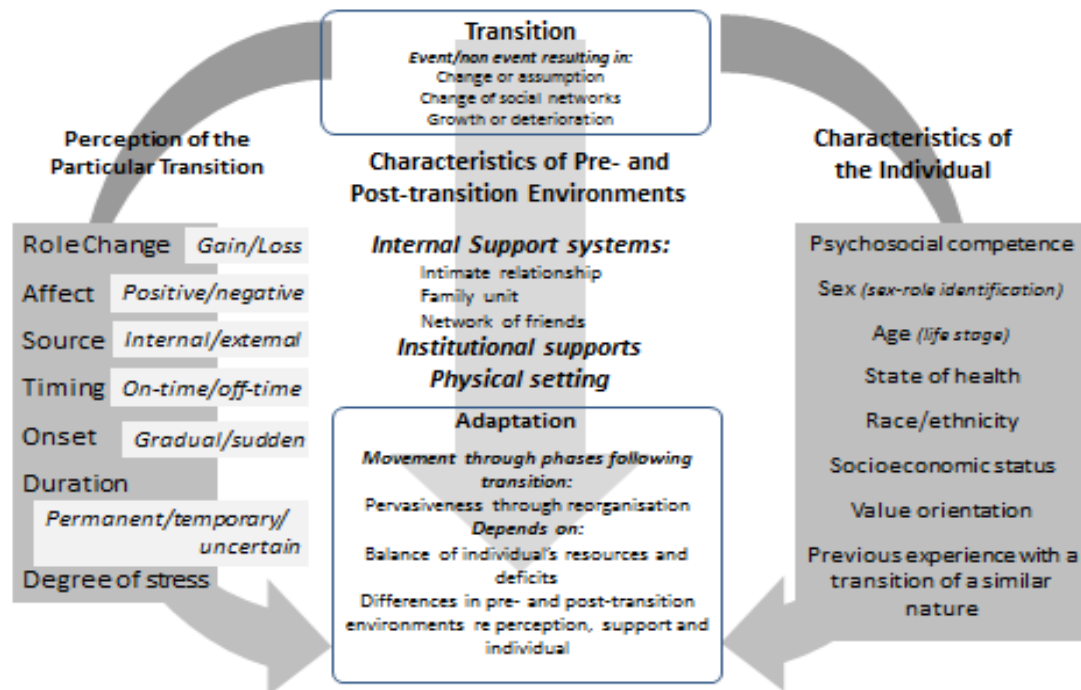


Figure 1.1: Schlossberg's Model for analysing human adaptation to transition

Source: Schlossberg (1981:5)

In the discussion to follow, the characteristics that influence adaptation to transition, as depicted in Figure 1.1 above, are elaborated upon.

From the perspective of Schlossberg's Transition Model (Anderson et al., 2012, in Peila-Shuster, 2016:56; Anderson et al., 2012:38; Schlossberg, 1981:5) transitions comprise the following:

- Approaching the transition: transition identification – its meaning, and the transition process.
- Taking stock of coping resources: the 4S-system (namely the situation, self, support, and strategies).
- Taking charge: strengthening one's resources.

These aspects will now be discussed in more detail.

1.4.1.1 Approaching the transition: Transition identification – its meaning, and the transition process

A transition can be perceived as a time of crisis or as a developmental adjustment, making the transition process one of pervasiveness to reorganisation (Anderson et al., 2012:39). Dealing with and adaptation to transitions requires inner and outer work; confronting the losses and confusion associated with transition. Transitions require taking risks in the face of associated fears, and calls for strategies to move through the crisis (Anderson et al., 2012:56).

How a person will proceed through the transition and on to adaptation post-transition will be determined by the type of transition encountered, the individual's perception of the transition, the context in which the event occurs, and the impact of the event on the person.

a) Types of or the nature of transitions

Transitions can be events or non-events that are either anticipated or unanticipated (Anderson et al., 2012:41). Anticipated or expected events may in the context of the TS graduating at the end of a particular year. Unanticipated or unpredictable events, for example the confirmation of a student's UP, may result in a crisis. Non-events are those events that are expected, but did not occur, for example when a student anticipated completing her tertiary qualification, but could not achieve this milestone due to an UP.

b) The characteristics of the transition itself

How transitions are perceived is dependent on the following characteristics of the transition (Peila-Shuster, 2016:56):

- **A transition can result in role change in terms of role gains or losses.** When an unintended pregnancy or TOP occurs, this could result in a role gain if the student chooses parenting as an option, or it could result in a role loss if she miscarriages or decides to terminate the pregnancy. Parenting could, however, also result in a role loss in terms of being a student and obtaining a qualification, and choosing a TOP could also imply a role gain if this choice enables her to continue with her studies and obtain a qualification.
- **A transition can have a positive and/or negative effect and be accompanied by a variety of feelings and emotional reactions.** This refers to and includes feelings and emotional reactions related to the suspicion and/or confirmation of an UP, such as shock, denial, disbelief, worry, loneliness, anger, guilt and shame (Barton et al., 2017; Akbarzadeh et al., 2016:191; Adams & Williams, 2011:1882), as well as the decision regarding and outcome of the UP.
- **A transition can be imposed internally and/or externally.** This refers to and includes the decision made regarding the unintended pregnancy, as well as the internal and external pressures and stressors that play a role in the decision and outcome, for example financial or academic pressure, or pressure from a partner/family member to continue with or terminate an UP. These aspects were referred to and discussed earlier in this chapter.
- **A transition can be viewed as “on-time” or “off-time”.** Pregnancy at tertiary level is seldom “on-time”, planned, or on the student’s agenda. There are very clear disadvantages to an UP, discussed earlier in this chapter – it poses a multiplicity of problems for students and academic institutions (Grey, 2014:1197; Naidoo & Kasiram, 2006:34) and it is therefore generally regarded as “off-time”.
- **The onset of a transition can be sudden or gradual.** In some instances, the occurrence of an UP is expected, for example when it is the result of unprotected sex or high-risk sexual behaviour. Most students however express shock, disbelief, and denial upon the suspicion/confirmation of an UP (Sereno et al., 2013:145; Seutlwadi et al., 2012:46; Sekgobela, 2008:1).
- **The duration of a transition can be permanent, temporary, or uncertain.** Being pregnant or terminating the pregnancy is a temporary process

characterised by high levels of stress and uncertainty, specifically regarding the pregnancy decision. The outcome of the decision regarding the UP, however, is permanent.

- **The final characteristic related to the transition itself, is the degree of stress.** Schlossberg (1981:9), however, states in this regard that the degree of stress involved is largely dependent on the characteristics already described. In other words any change, whether it represents a gain or a loss, or whether it is mainly positive or negative in effect, causes some stress.

- c) The characteristics of pre and post-transition environments hindering/promoting adaptation to transition

It is purported that an individual's ability to adapt to and integrate transitions is closely linked to the person's environment, with the latter encompassing interpersonal and institutional support systems available, as well as the physical setting (Schlossberg, 1981:10).

- **Interpersonal support**

Three types of *interpersonal support* are distinguished within the Transitional Model (Anderson et al., 2012:39; Schlossberg, 1981:2-16):

- Intimate relationships: this involves trust, support, understanding, and sharing with a partner that one is in an intimate relationship with and is of particular importance during stressful transitions (lack of partner support or pressure from an intimate partner/significant other to terminate the pregnancy has been found to negatively impact on the psychological adjustment in the decision-making process following an unintended pregnancy) (Sereno et al., 2013:147).
- The family unit: support from the family unit in times of transition is seen as crucial (for example, an unmarried, pregnant student receiving support from her parents will cope better with high stress levels) (Sereno et al., 2013:147).

- The network of friends: this is an important social support system (loss of the network of friends as a result of the shame or stigma attached to the occurrence of an UP or TOP has been found to exacerbate the difficulty of the transition) (Grey, 2014:1203).

- **Institutional Support**

Institutional support systems include occupational organisations, religious institutions, political groups, social welfare groups, and community support groups, as well as various outside agencies that one can approach for help and support (Schlossberg, 1981:11). A TOP support group offered by an NGO, for example, could assist in dealing with the feelings of shame, guilt, loss, and bereavement experienced in relation to the TOP.

- **Physical setting**

The importance of the physical setting in the context of supporting and/or compounding adaptation to transition with reference to aspects such as weather, location, neighbourhood, living arrangements, and workplace, is often overlooked. Schlossberg (1981:11-12) postulates that these factors, which were expanded to also include aspects such as personal space, comfort, and privacy, may contribute to stress or conversely to a general sense of wellbeing and thus contribute to adaptation transition (Schlossberg, 1981:12).

- d) The characteristics of the individual complementing and/or complicating adaptation to transition

The following individual characteristics are considered significant in affecting the ease or difficulty in terms of adaptation to transition (Schlossberg, 1981:15):

- **Psychosocial competence:** The success or failure of adaptation to transition is determined by an individual's level of psychosocial competence which, according to Tyler (1978, in Schlossberg, 1981:13), includes three types of attitudes that facilitate growth-oriented adaptation. These are:

- Self-attitudes: they include favourable self-evaluation, an internal locus of control, and a sense of responsibility.
- World attitudes: they include optimism/hope and moderate trust as the foundation for the development of constructive interaction with the world.
- Behavioural attitudes: they include an active coping orientation, high initiative, realistic goal setting, as well as the ability to plan and attain goals.
- Sex and sex role identification: includes the acknowledgement of different attitudes and behaviours, as well as the extent to which the individual internalises these norms, as these differences may significantly influence his/her ability to adapt (Schlossberg, 1981:13).
- Age and life stage: this includes the acknowledgement of life stage versus chronological age when dealing with transition. It is purported in this regard that “the processes for adequate coping may be life-stage-specific” (Lieberman, 1975 in Schlossberg, 1981:14).
- State of health: includes acknowledgement that an individual’s health affects his/her ability to adapt to a transition (Schlossberg, 1981:14).
- Race/Ethnicity: includes acknowledgement of other factors (such as value orientation and cultural norms) related to racial/ethnic background, in terms of an individual’s ability to adapt (Schlossberg, 1981:14).
- Socio-economic status: includes the acknowledgment that socio-economic differences may make a difference to the level of stress associated with different transitions (Hill, 1965 in Schlossberg, 1981:14).
- Value orientation: includes acknowledgement that an individual’s basic values and beliefs are a factor in his/her ability to adapt to transitions (Schlossberg, 1981:15).
- Previous experience with a transition of a similar nature: it is acknowledged that an individual who has successfully weathered a transition in the past will probably be successful at adapting to another transition of a similar nature (Schlossberg, 1981:15).

The purpose of the above-mentioned sets of characteristics affecting adaptation to transition is to facilitate a process that enables an individual to effectively deal with change. These sets interact to produce the outcome, namely adaptation or failure to adapt to transitions (Schlossberg, 1981:5). This is generally done by –

- Identifying the type and the nature of the transition and developing an understanding thereof. Determining whether the transition is *anticipated* or *unanticipated*, an *event* or *non-event* (Anderson et al., 2012:38; Schlossberg, 2011:159-160).
- Pinpointing the level of the impending change. Gauging whether it is interpersonal or relational.
- Specifying the degree to which the specific transition is impacting on the individual's life.
- Identifying where the individual is in the transition is also accentuated, as it is acknowledged that reactions to any transition change over time, depending on whether one is “moving in, through or out of the transition” (Anderson et al., 2012:38).

1.4.1.2 *Taking stock of coping resources – The 4S-system (situation, self, support, and strategies)*

In taking stock of coping resources, Schlossberg (2011:160-161) identified four features (known as the 4 S's) (Peila-Shuster, 2016:56; Anderson et al., 2012:38) common to all transitions resulting from events and non-events that influence a person's ability to cope with the transition. They are:

- **Situation:** This refers to an individual's situation at the time of transition, together with the presence/absence of other/additional stresses, and previous experiences of similar transitions (Workman 2015:5; Anderson et al., 2012:38; Schlossberg 2011:160). *In the context of this study, this would include the circumstances of the TS confronted with an UP and/or TOP. Is she a full-time student? What pressures and stressors is she experiencing?*

How does she view the timing of the transition? Does she perceive the transition as a gain or a loss, negative or positive, expected or dreaded? Where is she in the process of transition adaptation – is she in the beginning, middle, or end? What is her perception of the nature of transition? Does she perceive it to be of a temporary or permanent nature?

- **Self:** This refers to an individual's inner strength for coping with the situation and includes traits such as resilience and optimism (Schlossberg, 2011:160). *In the context of this study, this would refer to the pregnant student's psychosocial competence, which includes her self, world, and behavioural attitudes. This is of particular importance regarding the decision-making process regarding the UP – how will she cope with the outcome of the UP?*
- **Support:** Support refers to the people, organisations, or institutions the person can turn to for help with the transition (Workman, 2015:5; Schlossberg 2011:160). This includes professional associations or informal support groups. *In the context of this study this would refer to professional and informal sources of support available to assist the student confronted with an unintended pregnancy.*
- **Strategies:** This refers to the way in which an individual copes with the transitions and coping strategies that can be applied to change or reframe the situation in order to reduce stress (Workman, 2015:5; Schlossberg, 2011:161). *In the context of this study, this would include a review of the student's coping strategies. Is she applying just one strategy or is she applying various coping strategies? Are the chosen strategies harmful or helpful?* It has been found that individuals who remain flexible and apply multiple coping strategies manage transitions better than those who opt for only one coping strategy (Schlossberg, 2011:161).

1.4.1.3 Taking charge: Strengthening one's resources

Apart from utilising and strengthening the aforementioned coping resources, taking charge also implies enlisting alternative support and adopting and implementing new coping strategies, as well as an acknowledgement that “although some transitions are out of our control, we can control the way we manage them” (Anderson et al., 2012:38).

In summary, I decided on Schlossberg's Transition Process Model as theoretical framework for this study, “as it provides a structural approach that honors the variability of each individual” (Peila-Shuster, 2016:56). This model allows for the development of an understanding of how students with UPs and who have had TOPs who report for psychosocial support identify the transition; how they view and experience the transition process; and the strategies and support to their avail to navigate the transition (Peila-Shuster 2016:55-56; Schlossberg 1981:5).

Following the identification and explanation of the theoretical framework adopted for this study, the key concepts central to this study will now be clarified.

1.5 CLARIFICATION OF KEY CONCEPTS

In this section, the key concepts that I deem to be relevant and central to this study will be clarified. The importance of conceptualisation in this regard is emphasised by Babbie (2010:12) who explains this as a process during which researchers get the opportunity to clarify what they mean when they use a specific term in the context of their study. This process involves the refinement and specification of abstract terms in order to clarify their operational meaning in relation to the research study and is regarded as a means to avoid confusion.

Below is the conceptualisation of my understanding of the following key concepts.

1.5.1 Experiences

The word “experience” refers to knowledge, skill, or wisdom gained through involvement in or exposure to some activity, incident, or ordeal. It furthermore implies that a person has first-hand knowledge (as a result of something personally encountered, undergone, or lived through) of conditions, circumstances, feelings or sensations (*Cambridge Online Dictionary*, n.d., sv “experience”).

The act or process of directly perceiving events or reality, as well as the effect on a person of anything or everything that has happened to that person (individual reaction to events, feelings, etc.) is included in the clarification of this concept (*Merriam-Webster Online Dictionary*, n.d., sv “experience”).

In latching on to the above-mentioned definitions, Soanes, Spooner and Hawker (2001:311) describe an experience as an event that leaves an impression on a person, while Van den Bos (2007:354) refers to it as “a conscious event that is lived through and not imagined or thought about”. The concept is furthermore seen as inclusive of the totality of a person’s feelings, observations, and memories (Collins, Coffey & Morris, 2010:581).

For the purposes of this research study, the concept “experiences” (and the exploration thereof in order to address the concerns of the populations) refers to the sum total of all emotions, behaviours, circumstances, pressures, decisions, and support experienced and lived through in relation to UPs and TOPs amongst TSs.

1.5.2 Guidance, guidelines, and practice guidelines

Guidance is described as to direct, to point out, offer supervision or to show the way (Allan & Moffett, 2016:447). It entails advice, information, or assistance aimed at

resolving a problem or challenge, offered by a competent counsellor to an individual to help him/her direct his/her life, develop his/her own point of view, make his/her own decisions, and solve his/her own problems (Allan & Moffett, 2016:447; *Oxford Living Dictionaries*, n.d., sv “guidance”). It is emphasised that this process should not be an order, an imposition of one’s ideas on others, or a decision made for others, but rather a continuous, client-centred process inclusive of all activities which promote individual self-realisation (Allan & Moffett, 2016:447) and the maximum development of an individual in terms of the possibilities available to him/her (Allan & Moffett, 2016:448)

A *guideline* is seen as a statement or strategy by which to determine a course of action. It could assist with addressing certain social problems. It relates to what to do when addressing social problems as well as how to do it, through activities, techniques, or projects (Hepworth, Rooney, Rooney, Strom-Gottfried & Larsen, 2013:435).

Proctor and Rosen (2003:109) define *practice guidelines* in social work as “a set of systematically compiled and organized statements designed to enable practitioners to find, select and use appropriately the interventions that are most effective for a given task”. Proctor and Rosen (2003:109) and Hepworth et al.’s (2013:435) definitions of the concept practice guidelines are adopted for this study with the aim of the practice guidelines being to indicate, point out, and show the way (Allan & Moffett, 2016:447) in terms of providing psychosocial support to TSs with an UP and TOP.

1.5.3 Needs

A need is seen as a necessity – a physical, physiological or psychological condition – often originating because of a lack of something required for wellbeing (*Cambridge Online Dictionary*, n.d., sv “needs”; *Merriam-Webster Online Dictionary*, n.d., sv “needs”).

Within the context of this research study, the concept “needs” (and the exploration thereof in order to address the concerns of the populations) refers to and includes the material, emotional, relational, and spiritual resources required by the population when dealing with the problem of an UP and/or TOP. The mentioned resources, also described by several scholars as “support needs” (Schenck, Roman, Erasmus, Blaauw, & Ryan, 2017:268-269; Botha, 2014:68; Petty, 2014:257), are specified in terms of Max Neef’s model²⁰ which identifies it in terms of the following fundamental human needs (FHNs):

- Subsistence (food, shelter)
- Protection (safety, security)
- Affection (care, family, relationships)
- Understanding (education)
- Participation (decision-making)
- Idleness (leisure experiences)
- Creation (to concentrate, work)
- Identity (the self of the person, values)
- Freedom (rights, equal access)
- Transcendence (spirituality)

1.5.4 Post Abortion Stress/Syndrome (PAS)

PAS is a particular form of a larger diagnosis known as PTSD (Curley & Johnston, 2013:279). It is described as the psychological, emotional, and spiritual trauma caused by the termination of a pregnancy, which is an event outside the normal range of human experience (Rocca et al., 2015; Curley & Johnston, 2013:279).

²⁰ Max-Neef (1991), a Chilean economist and environmentalist, identified nine FHNs that all people experience (Schenck et al., 2017:268), with a 10th one added later (Botha, 2014:68). These FHNs are seen as infinite and part of the human being as a whole and, if one dimension of the FHNs is not met, the person is affected in total, which could lead to an increase in the vulnerability of the person (Schenck et al., 2017:269).

PAS, in the context of this research study, refers to a type of post-traumatic disorder that develops when a woman is unable to go through a normal grieving process for the loss of her child. The woman then develops a pattern of defence mechanisms, which prevents the release of pain, guilt, shame, grief, and anger and so blocks the healing process. The characteristics of PAS are categorised according to the symptoms of PTSD, as it appears in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (Curley & Johnston, 2013:279; Goodwin & Ogden, 2007:231; Trybulski, 2006:684; Speckhard & Rue, 1992:95-103). These characteristics include the experience of post-termination sequelae, and psychological- and behavioural disturbances, elaborated upon extensively earlier in this chapter (see Section 1.1.2.5).

1.5.5 Pregnancy

Pregnancy is the gestational process, comprising the growth and development within a woman's uterus of a new individual from conception through the embryonic and foetal periods to birth (*Oxford Living Dictionaries*, n.d., sv "pregnancy"; Anderson, 2002:1389, sv "pregnancy"). This clarification is affirmed by Stoyles (2015:92) and Gold (2005:7) who state that the medical community has long been clear regarding the question of when a woman is considered to be pregnant, namely that pregnancy is established when a fertilised egg has been implanted in the wall of a woman's uterus.

The following concepts related to pregnancy need clarification in terms of the context of this research study:

- **UP (also known as an "unintended" or "unwanted" pregnancy)**

UP is explained by Grussu et al. (2005:107) as a pregnancy that occurred when the clear intention to become pregnant was lacking. UPs include those reported by women to be unwanted or mistimed. This refers to when a woman knows that she would like to have a baby in the future, but becomes pregnant sooner than

she wanted to, but also includes when a woman who knows that she does not want a baby now or in the future becomes pregnant (Wellings et al., 2013:1807; Martino, Collins, Ellickson & Klein, 2006:68).

In the context of this study, the term 'UP' refers to a pregnancy that occurred without advanced planning during the period of a student's tertiary education and is thus perceived to be unexpected, unplanned, mistimed, and unwanted.

- **Crisis pregnancy**

A pregnancy becomes a crisis when the woman perceives the pregnancy to be a threat to or a problem for her emotional and physical wellbeing. The pregnancy is perceived as a threat because of the people in her life, for example desertion by the birth father or a lack of support from her parents; because of the circumstance that exist, such as being unemployed or a full-time student; and/or the pressures she is experiencing, such as financial problems (Hill, 2015:59; *Oxford Living Dictionaries*, n.d., sv "crisis pregnancy").

1.5.6 Service provider (SP)

For the purpose of this research study, the term service provider(s) is used as an inclusive term that refers to professional practitioners rendering professional support services. Such services may include counselling, education, guidance, and intervention, as well as medical support/intervention to students within the context of higher/tertiary education. A professional practitioner is someone who is engaged in the practice of an occupation or a learned profession (*Cambridge Online Dictionary*, n.d., sv "professional practitioner") and, in this context, collectively describes volunteer counsellors, healthcare professionals, social workers, and psychologists.

1.5.7 Social work

At their General Meeting and Assembly held in July 2014, the International Federation of Social Workers (IFSW) approved the following definition of this concept (IFSW, 2012):

Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing.

Social work can also be described as a profession devoted to helping people to function best in their environment, and which has its own body of knowledge, code of ethics, and practice standards (National Association of Social Workers, n.d.). Both of these definitions are applicable within the context of this research study.

1.5.8 Social worker

This term refers to the duly registered person authorised in terms of the Social Service Professions Act 110 of 1978 (South Africa, 1978), as amended, to practise the profession of social work.

According to Zastrow (2010:38), this concept applies to graduates of Bachelor's or Master's level social work programmes who are employed in the field of social welfare. De Vos, Schulze and Patel (2005:17) define a social worker as a well-trained professional with a theoretical knowledge base of methods and techniques for participating in wider social action and policy development. Social workers are seen as change agents and committed professionals who are skilled at working with individuals, groups, families, organisations, and communities to help them achieve the best possible outcomes (Thompson & Thompson, 2016:xxix). In the context of this study, the concept social worker refers to a person who has qualified and is practicing within the profession of social work.

1.5.9 Student

A student refers to a person engaged in study; one who is devoted to learning; a learner, pupil, or scholar, especially one who attends a school or who seeks knowledge from professional teachers or books (*Longman Dictionary of Contemporary English*, 2003:1020, sv “student”). A student can also be defined as a person studying at a university or other place of higher education to enter a profession (*Oxford Living Dictionaries*, n.d., sv “student”). The latter definition is relevant within the context of this research study.

As mentioned earlier in this chapter, the client system group identified for this research study, namely TSs, could also refer to or be inclusive of adolescence, late adolescence, and the youth. These concepts are consequently clarified:

1.5.9.1 *Adolescence, late adolescence, and the youth/young people*

The WHO (2011:1) refers to the youth/young people as individuals between the ages of 10 and 24. Adolescents are defined as young people between the ages of 10 and 19 (WHO, 2011:1), while Sigelman and Ryder (2006:305) describe the life stage from 18 to 22 as “late adolescence”.

In South Africa, young people are defined as those falling within the age group of 14 to 35 years (South Africa, 2015), with the National Adolescent and Youth Health Policy 2017 (Department of Health, 2017:1) and several other scholars (Isdale, Reddy, Winnaar & Zuze, 2016; SAACHDE, 2010; Marteleto, Lam & Ranchhod, 2009:353) describing the life stage from age 10 to 19 years as adolescence and 20 to 24 years as late adolescence and/or the youth.

The average age of the majority of young people who make the transition from secondary education to tertiary education seems to be between 18 and 22 years (Ellis & Bliuc, 2016:971; Schleicher, Harris, Catley & Nazir, 2009:508). Within the context of

this study, it can therefore be deduced that the average TS can be considered to be in adolescence or late adolescence (Bhorat, Lilenstein, Magadla & Steenkamp, 2015; Saddock & Saddock, 2003:35; Lenz, 2001:302) with this life stage relating to Phase 5 (“Identity versus Identity diffusion”) of Erikson’s Psychosocial Development Theory (Jordán-Conde et al., 2014:356; SAACHDE, 2010; Saddock & Saddock, 2003:35)²¹.

1.5.10 Support

The term ‘support’ signifies the rendering of assistance or help (*Merriam-Webster Online Dictionary*, n.d., sv “support”). Within the context of social work, this refers to and includes “helping individuals, families, groups and communities to enhance their individual and collective well-being” (IFSW, 2012). The main aim with regard to social work support is to help people develop their skills and their ability to use their own resources and those of the community to resolve problems (National Association of Social Workers, n.d.). Support in this field, amongst others, relates to concern with individual and personal problems, but also relates to broader social issues, such as poverty, unemployment, and domestic violence (Hepworth et al., 2013:5).

Support to TSs generally consists of the provision of specialised services, rendered by professionals, with the purpose of assisting those who are facing barriers to learning to achieve their educational and developmental goals. The rendering of support services to students are furthermore seen as critically important for their social, emotional, and character development (Russo-Gleicher, 2013).

The function of support services to TSs, according to Beekman and Scholtemeyer (2012:266), is threefold, namely cognitive, affective, and systemic, and the rendering thereof refers to a variety of integrated activities within administrative, academic, and social sub-systems with the purpose of facilitating professional and personal growth (Botha, 2014:67).

²¹ An elaboration of the life stage (with its unique challenges and expectations) of the TSs who participated in this study is presented in Chapter Four of this research report.

Within the context of this research study, support services to TSs with UPs and TOPs refer to and include professional and non-professional support as types of support:

- *Professional support services* are rendered by professionals, for example social workers, psychologists, trained volunteer counsellors, and healthcare professionals. These services tend to be formal and may include counselling (therapeutic support and intervention), education (the provision of information with the purpose of creating awareness of issues related to an UP and TOP, as well as the prevention of this phenomenon), and/or medical assistance information, advice, treatment, and support. TSs may choose to access/utilise these services on campus, via the institutional support service (student counselling or campus clinic/health) offered by the tertiary institution. They may also choose to access/utilise these services off campus, for example via welfare organisations such as Christian Social Services, NGOs such as the CPCCs, government organisations such as the Department of Social Development, private healthcare facilities, community clinics, or government hospitals.
- *Non-professional (informal) support services* to TSs with UPs and TOPs generally refer to and include informal forms of support (such as emotional support or financial assistance) from parents, family members, friends, lecturers, peers, and/or the students' partner/boyfriend.

In latching on to the above-mentioned clarification of this concept, and to ensure further clarity, the notion of support within the context of this study can be described as an intervention, inclusive of counselling and education, that addresses the psychological and social problems experienced by the TS confronted with an UP or TOP (Tol et al., 2011). The purpose of support in this regard is to meet the relevant emotional, cognitive, social, physical, and spiritual needs of this client system group through interactions with their surroundings and the people who care for them. This process includes rebuilding and strengthening relationships and it furthermore aims to assist the student confronted with an UP and/or TOP to respond adequately to the

stressors that create barriers to learning to achieve their educational and developmental goals (namely to remain in higher education and eventually graduate).

1.5.11 TOP (also referred to/known as “abortion”)

The term “abortion” is often used to describe the induced termination of a pregnancy (Stoyles, 2015:97; Moscrop, 2013:99). In this regard, I wish to acknowledge that the term “abortion” can be perceived as highly emotive, as it might carry a suggestion of criminal activity or imply illegality (Macagno & Walton, 2014:3). I will therefore apply the term “termination of pregnancy” and/or the acknowledged abbreviation thereof (TOP) for the purposes of this research study. The term “abortion” will only be used when directly quoted by an author or when it is deemed appropriate and relevant within the context of the study.

TOP refers to the deliberate termination of a human pregnancy before the foetus has developed sufficiently to live outside the uterus (Stoyles, 2015:97). It is also often described as the expulsion (either spontaneous or induced) of a foetus from the womb before it is able to survive independently (Moscrop, 2013:99). In the context of this study, the concept “TOP” could also refer to or be inclusive of the following:

- **Spontaneous TOP**

A TOP can occur spontaneously due to complications during pregnancy or it can be induced. Spontaneous TOPs are described as the natural death of a foetus before it is able to survive independently; in other words, before 20 weeks of gestation. This is usually called a miscarriage, while a spontaneous TOP after 20 weeks of gestation is referred to as a stillbirth (Stoyles, 2015:97-98; Moscrop, 2013:99-100).

- **Induced TOP**

An induced TOP is “the termination of pregnancy through a deliberate intervention intended to end the pregnancy” (Sedgh, Henshaw, Singh, Ahman & Shah, 2007:1338). Reasons for procuring induced TOPs are typically characterised as either therapeutic or elective. There are two types of induced TOPs, namely medical and surgical TOPs. Medical TOPs are non-surgical abortions that use pharmaceutical drugs, and this procedure is only effective in the first trimester of pregnancy (Ireland, Gatter & Chen, 2015:23; DISA Sexual and Reproductive Health Clinic, n.d.). With a surgical TOP, instruments are used to remove the contents of the uterus. Surgical procedures that may be used, depending on the gestational age (time since last period), include manual or electric vacuum aspiration (MVA or EVA), dilation and curettage (D&C), or intact dilation and extraction (IDX) (Ireland et al., 2015:23; *Oxford Living Dictionaries*, n.d., sv “surgical abortion”).

- **Therapeutic TOP**

A TOP is medically referred to as therapeutic when the pregnancy constitutes a threat to the physical or mental health of the pregnant woman, or if the unborn baby has severe birth defects. It is performed to save the life of the pregnant woman; preserve the woman’s physical or mental health; or prevent a birth characterised by a congenital disorder that could be fatal (Moscrop, 2013:100).

- **Elective TOP**

An elective TOP is defined as the interruption of a pregnancy before the 20th week of gestation at the woman’s request for reasons other than maternal health or foetal disease (Ireland et al., 2015:23; *Oxford Living Dictionaries*, n.d., sv “elective abortion”).

- **Safe TOP**

Sedgh et al. (2007:1339) define safe TOPs as TOPs in countries where abortion law is not restrictive or TOPs that meet legal requirements in countries where the law is restrictive. The WHO (2012:63) furthermore defines this concept as a procedure for terminating an unintended pregnancy, carried out by persons having the necessary skills in an environment that conforms to minimal medical standards.

- **Unsafe TOP**

The WHO (2009) defines an unsafe TOP as “a procedure... carried out by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards or both”. Unsafe TOPs are sometimes known colloquially as “back-alley” terminations, usually performed by a person without medical training, a professional health provider operating in sub-standard conditions, or by the woman herself (Ireland et al., 2015:23).

- **Multiple TOPs**

Multiple TOPs (also known as repeat abortions) are defined as “two or more TOPs by a woman” (Picavet et al., 2013:328).

1.6 OUTLINE OF THE RESEARCH REPORT

This research report will comprise of seven chapters.

In Chapter One an introduction and general orientation to the research study, as well as a motivation for this research endeavour, is provided. The theoretical framework adopted for the study is introduced. The key concepts central to the study are clarified and the content plan for this research report is provided.

In Chapter Two the proposed research plan for the study will be introduced, together with the research questions, goals, and objectives for the study. In terms of the research plan, the research approach, design, and research methods will be introduced and the proposed ethical considerations to be honoured during the study will be highlighted.

Chapter Three consists of a detailed description of my application of the qualitative research process, with specific reference to the implementation of the appropriate research methodology.

A description of the research findings relating to the experiences, support, and support needs of TSs with UPs and TOPs, as well as their suggestions to inform practice guidelines for psychosocial support, is presented and subjected to a literature control in Chapter Four.

In Chapter Five, the findings relating to the perceptions of SPs regarding the experiences and support needs of TSs presenting with UPs and/or TOPs, the scope of support services offered by them to this client system group, and their suggestions for informing practice guidelines for psychosocial support to said students are presented and also subjected to a literature control.

Chapter Six consists of the practice guidelines for psychosocial support, developed from a social work perspective, to assist SPs in their service delivery to TSs presenting with an UP and/or TOP.

In Chapter Seven, the final chapter of this research report, the conclusions arrived at and the recommendations to inform possible further research are presented.

1.7 CHAPTER SUMMARY

The first chapter of this research report served as an introduction and general orientation to the study. A theoretical background, consisting of a presentation of the prevalence of, increase in, and consequences of unintended pregnancies and TOPs, was provided. The research problem and the rationale for the study were explained. The theoretical framework that was adopted for this study, namely Schlossberg's Transitional Model (Schlossberg, 1981:5), was described and supported by a motivation for its selection and inclusion in this study. The final section of this chapter consisted of a clarification of the terminology used in this research report. The chapter concluded with an overview of the remaining six chapters.

In the next chapter, the proposed research plan for investigating the identified research problem will be introduced.

CHAPTER TWO: THE PROPOSED RESEARCH PLAN – AN INTRODUCTION

2.1 INTRODUCTION

The first chapter of the thesis was, amongst others, devoted to introducing and providing a backdrop to the topic chosen for investigation. The problem pointing to and the motivation for embarking on this research journey were highlighted and the theoretical framework adopted for the study was introduced.

In this chapter, the research questions formulated to address the problem identified are introduced. The goals and objectives prepared to answer the stated questions and the proposed research plan for this investigation are also presented.

The research plan introduced in this chapter was initially presented as part of a research proposal submitted to the Research and Ethics Committee of the Department of Social Work at the University of South Africa (UNISA) where I was enrolled for my doctoral studies in Social Work, for review and ethical approval. The same proposal, together with the ethical approval certificate issued (by the mentioned committee) was also presented at the other universities'²² ethical review committees in order for them to grant the permission necessary for me to conduct the study at their institutions amongst their students and SPs.

In looking at the research proposal or plan, Punch (2016:2) suggests that researchers keep the “four Ps” (phase, process, product, and plan) in mind when drafting a research plan. The research plan is a distinct *phase* in the research process – it is the first phase and relates to the launch of the research project. Drawing up a research plan entails a *process* of planning and designing the research, culminating in a *product*, namely a formal research proposal (submitted for review and ethical

²² I approached and invited four institutions of higher education in Gauteng to participate in this research endeavour.

approval), or a chapter (such as this one), in a research report (thesis) as a proposed research *action plan* for a study. In the next section the research questions, goals, and objectives are presented, as these aspects have a direct bearing on the research plan.

2.2 RESEARCH QUESTIONS

In focusing on the aspect of the research question in research planning, Locke, Golden-Biddle and Feldman (2011 in Punch, 2016:18) recommend “a logical sequence of problem, question, [and] purpose... as the way forward... in proposal development”. Reflecting on this suggested sequence, I deduce that the research question(s) evolve from the research topic, or the research problem – a view shared by Alford (in Hennink, Hutter & Bailey, 2011:34). The translation of a research problem or topic into a researchable question in the early stages of a study is vital, as such a question(s) frames the outline and process, lays the foundation, and signifies what has to follow (Yates & Leggett, 2016:225-226; Mills & Birks, in Mills & Birks, 2014:11; O’Leary, in D’Cruz & Jones, 2014:22). The research question refers to the question that the study wants answered in relation to the phenomenon being investigated and in addressing the articulated research problem (Creswell, 2014:122-134; Neuman, 2012:90-91; Ratele, in Terre Blanche, Durrheim & Painter, 2006:540-541). In explaining the meaning of the concept “research question”, Hennink et al. (2011:33) write the following:

Research questions are questions that you propose to answer through data collection. They guide all other subsequent tasks in the research process. At the end of the project, after data collection and analysis, you should be able to answer the research questions. Research questions therefore help you to keep focused during the research project.

Based on these introductory pointers on the functions of research questions in the research process, and in keeping to the sequential suggestion of Locke et al. (2011, in Punch 2016:18) that the research questions should be based on and flow from the articulated research problem identified, I deemed it necessary to restate the problem statement initially presented in Section 1.2:

In spite the prevalence of, and increase in UPs and TOPs as a real-life problem with detrimental effects on the students, their significant others, and tertiary institutions, there seems to be a stillness in the literature with reference to practice guidelines for psychosocial support from the ambit of social work to assist SPs in their service delivery to TSs presenting with UPs and/or TOPs. The development of such guidelines should be informed by and based on the experiences, needs, and suggestions of TSs who had an UP and/or TOP, as well as the perceptions and suggestions of SPs rendering psychosocial support services to said students.

Based on this problem statement, I formulated the following research questions to inform the subsequent steps, guide the research process, and address the identified research problem.

As my initial plan was to sample participants from two interest groups for study, namely TSs who had an UP and/or a TOP and SPs rendering support services to such students, I set out to formulate guiding research questions directed at both these groups.

Focusing specifically on the **TSs**, the following research questions to guide the study were formulated:

- How did TSs experience their UPs and/or TOPs?
- What support needs did TSs experience in relation to their UPs and/or TOPs and how were they supported?
- What are TSs' suggestions for practice guidelines for psychosocial support to TSs presenting with UPs and/or TOPs?

The following research questions were developed to steer the investigation in respect of the **SPs** in particular:

- What are the perceptions of SPs rendering support services to TSs with UPs and/or TOPs about the experiences and support needs of these students?

- What are the scopes of the support services offered by SPs to TSs presenting with UPs and/or TOPs?
- What are the suggestions of SPs rendering support services to TSs with UPs and/or TOPs for informing practice guidelines for psychosocial support to said students?

2.3 THE RESEARCH GOALS AND OBJECTIVES

Like the research question, the purpose or goal of the research advances from the research problem which needs attention or a solution (Punch, 2016:9). Likewise, the goal and the research questions are linked in that in the process of answering the latter, the goal of the research is realised. In connecting with this link between the research question and the goal, O’Leary (2017:373) states that the goal is a restatement of the research question. In the context of research, the concept “goal” refers to the overall intention of the research and points to the reason why a research project is undertaken and what the researcher wants to accomplish by doing it (Punch, 2016:9; Creswell, 2014:134; Maxwell, 2013:23). Maxwell (2013:24, 28) distinguishes three different kinds of goals for conducting research, namely personal, practical (research), and intellectual goals. At a personal level, the desire to change or improve a problematic situation or curiosity about a specific topic can prompt a researcher to embark on a research journey. These personal level goals may overlap with the practical goals which are directed at accomplishing something, for example meeting a need or changing a situation. Intellectual goals, on the other hand, are aimed at understanding something, or developing insight into a phenomenon, or addressing a question not adequately addressed in previous research.

From the introductory remarks on the aspect of the research goal, and the kinds of research goals as highlighted by Maxwell (2013:24, 28), I formulated the following practical and intellectual goals for this study, *inter alia* informed by personal motivations.

As two sets of research questions were formulated at the outset, with the focus being on the TSs and SPs respectively, two sets of goals were developed.

Emerging from the research questions pertaining to the **TSs**, two goals were formulated to steer the process of answering the first set of research questions, namely to –

- develop an in-depth understanding of the experiences, support, and support needs of TSs who have had an UP and/or a TOP; and
- proffer practice guidelines to SPs for the provision of psychosocial support to TSs presenting with UPs and/or TOPs, based on the experiences, needs, and suggestions of the students concerned.

In order to answer the research questions formulated in respect of the **SPs**, the following goals emanated namely to –

- develop an in-depth understanding of the perceptions of SPs rendering support services to TSs presenting with UPs and/or TOPs based on the experiences and support needs of these students;
- gain insight into the scopes of the support services offered by SPs to TSs presenting with UPs and/or TOPs; and
- proffer practice guidelines to SPs for the provision of psychosocial support to TSs presenting with an UP and/or a TOP informed by SPs' suggestions based on their perceptions of the experiences and needs of these students and the scopes of the support services offered.

In view of realising the aforementioned goals, research objectives were proposed. Research objectives, to quote Grove, Burns and Gray (2013:708), refer to “clear, concise, declarative statements that are expressed to direct a study”. Simply stated, research objectives describe what the researcher will do in order to assist in achieving the goal(s) of the study (Denscombe, 2012:85; Babbie 2007:14). Objectives therefore serve as practical guides in terms of what exactly needs to be investigated to achieve goal realisation.

I proposed the following **task and research objectives** (illustrated in Table 2.1 and depicted in sequence) in order to attain the goals of this research study.

Table 2.1: The task and research objectives of this research study

Task Objectives	Research Objectives
To obtain a sample of TSs who have experienced an UP and/or TOP.	
To conduct in-depth, semi-structured, face-to-face interviews with the sampled TSs.	To explore the TSs' experiences, support, and support needs in relation to their UPs and/or TOPs, and based on and in addition to these, invite suggestions to inform practice guidelines for psychosocial support to students presenting with an UP and/or a TOP.
To obtain a sample of SPs rendering support to TSs with UPs and/or TOPs.	
To conduct focus group discussions with the sampled SPs.	To explore - <ul style="list-style-type: none"> - SPs' perceptions of TSs' experiences and support needs related to UPs and TOPs; - the scopes of the support services offered by SPs to TSs presenting with an UP and/or a TOP; and - SPs' suggestions to inform practice guidelines for psychosocial support based on their perceptions of the experiences and needs of students with UPs and/or TOPs, as well as the scopes of the support services offered to said students.
To sift, sort, and analyse the data obtained from the TSs and the SPs using Tesch's eight steps for qualitative data analysis as cited in Creswell (2014:198).	
	To describe the explored – <ul style="list-style-type: none"> - experiences, support, and support needs of TSs in relation to their UPs and/or TOPs, and the suggestions based on these to inform practice guidelines for psychosocial support to students presenting with an UP and/or a TOP; - SPs' perceptions of TSs' experiences and support needs related to UPs and/or TOPs; - scopes of the support services offered by SPs to TSs presenting with an UP and/or a TOP; and - suggestions forwarded by SPs to inform

	practice guidelines for psychosocial support to students presenting with an UP and/or TOP based on SPs' perceptions of these students' experiences and needs, in order to develop such practice guidelines.
To conduct a literature control to verify the findings.	
To provide an overview of the legislative and policy frameworks informing the provision of psychosocial support to women presenting with UPs and/or TOPs and underpinning the practice guidelines proffered for the provision of psychosocial support to tertiary students presenting with an UP and/or TOP.	
	<p>To draw conclusions on –</p> <ul style="list-style-type: none"> - the experiences, support, and support needs of TSs in relation to their experience of an UP and/or TOP, as articulated by the mentioned students and based on the perceptions of SPs rendering support to them; and - the scopes of services offered by SPs to TSs presenting with an UP and/or a TOP. <p>To make recommendations based on and informed by the empirical and literature search undertaken on –</p> <ul style="list-style-type: none"> - the experiences, support, and support needs of TSs presenting with an UP and/or TOP; - the experiences and support needs of TSs with an UP and/or TOP from the vantage point/perception of SPs rendering support services to these students; - the scopes of support services offered by SPs to TSs presenting with UPs and/or TOPs; and - the suggestions forwarded by both the TS and SP-participants by proffering practice guidelines for psychosocial support to assist SPs in their service delivery to TSs presenting with an UP and/or a TOP.

2.4 RESEARCH METHODOLOGY

In explaining the concept “research methodology”, Leedy and Ormrod (2005:12) write that it is the “general approach that the researcher takes in carrying out the research project”, with such an approach dictating, to some extent, the particular tools that the researcher selects. They further emphasise the importance of not equating the

“research method” with the “research methodology”. The research method refers to a set of specific tools, techniques, and procedures employed for the purpose of obtaining a sample of participants, and for how the data will be collected and analysed (Wahyuni, 2012:72; Leedy & Ormrod, 2005:12). The research methodology, on the other hand, refers to the research process in terms of the research approach and design (Carter & Little, 2007:1318). Metaphorically, the methodology can be equated as the map and the method as the set of steps to travel between two places on the map (Jonker & Pennink, 2010, in Wahyuni, 2012:72). The logic behind the procedures and techniques, such as the research methods applied in a research study is explained by the research methodology (Welman, Kruger & Mitchell, 2005:2). Babbie and Mouton (2010:46) state that the choice of research methodology for a research study is dependent on the research questions and goals of a study. Being cognisant of this, I will now present the research approach and design adopted for this study and in the next section of this chapter I will introduce the research methods and techniques, with reference to sampling and the methods of data collection, analysis, and verification proposed for this endeavour.

2.4.1 Research approach

The approach, whether quantitative, qualitative, or a mixed method research approach, adopted for investigating a chosen research topic is influenced by a researcher’s “worldview” or “basic set of beliefs that guide action” (Guba, 1990 in Creswell, 2014:6) or what is referred to as the constructs of ontology, epistemology, and axiology (Creswell, 2014:6). *Ontology* relates to one’s view or position on the form and nature of reality (what is there). It is described as a belief system that reflects an interpretation of an individual about what constitutes a fact, providing us with a corresponding view of knowledge (Thomas, 2017:122; Kramer-Kile, 2012:28; Morrow, 2007:212). *Epistemology*, according to Kramer-Kile (2012:38), is often described as “the theory of knowledge”, as it asks what the basic belief about knowledge is, what can be known; how does knowledge come to be known, the relationship between the knower and the known, as well as the characteristics,

principles, and assumptions that guide the process of knowing and the achievement of research findings (Thomas, 2017:123; Wahyuni, 2012:69-71; Morrow, 2007:212). In short, Thomas (2017:123) sums up ontology and epistemology as follows: “Ontology is about what you are looking at – the kinds of events that exist in the social world. Epistemology is about *how* you look and find out about these.” *Axiology* centres on the role of the researcher’s own values in research or his/her stance in the research process, in other words how the researcher goes about finding out whatever he/she believes can be known (Wahyuni, 2012:69-71; Morrow, 2007:212).

In reflecting on the research questions formulated for this study (see Section 2.2), as well as the goal of developing an in-depth understanding or a “*verstehen*”²³ of the topic being investigated (see the goals in Section 2.3), I became aware of the fact that there cannot be a single answer to these questions, but rather there will be as many answers and realities as there are participants. This called for an *interpretivist paradigm*, or what is subscribed to as constructivist worldview (Creswell, 2014:8; Wahyuni, 2012:71) to be adopted.

This mentioned paradigm underlies qualitative research (Flick, 2015:24; Creswell, 2014:8; Hennink et al., 2011:11, 16). Interpretivism is implanted in a relativist position of reality – a belief that there's no absolute truth, only the truths that a particular individual or culture happen to believe (Morrow, 2007:212). Researchers operating from an interpretivist paradigm acknowledge the fact that reality is socially constructed through the social interaction they have with research participants relating to these participants’ experiences (and the meanings they attach to these) occurring in various contexts – namely personal, social, and cultural (Thomas, 2017:110; Flick, 2015:24; Wahyuni, 2012:71; Hennink et al., 2011:15). In addition, when looking at reality through an interpretivist lens, the researcher admits to the fact that reality is subjective, due to the subjectivity of people’s perceptions and

²³ The concept “*verstehen*”, to quote Hennink et al. (2011:18), “refers to [the researcher achieving an] understanding of the issues from the interpretive framework of the study population, or from the ‘insider perspective’.” *Verstehen* is paramount for the qualitative researcher, as he/she wants to come to know the subjective meaning people attach to their experiences and views.

experiences. Furthermore, perspectives on reality are multiple, advocating for the existence of multiple truths on reality (Hennink et al., 2011:15). On the question of how knowledge can become known or how one can achieve an understanding (*verstehen*) of the phenomenon being investigated, Wahyuni (2012:71) avers that “interpretivist researchers favour to interact and have dialogue with the studied participants...”. In terms of the qualitative researcher’s stance in the research process (axiology), he/she takes an emic stance or an insider’s perspective by studying the social reality from the perspective of the participants themselves (Hennink et al., 2011:18). Both the researcher and the participants will bring their values to the party and influence the collection and the analysis of the data (Wahyuni, 2012:72).

The focus of the discussion will now shift to the introduction of the qualitative research approach as the approach adopted and proposed for this study, as it is customarily linked to an interpretivist paradigm (Flick, 2015:24; Hennink et al., 2011:16).

Qualitative research, to quote Creswell (2009:4), can be described as a “means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem”. It allows researchers to examine people’s experiences (Hennink et al., 2011:9). Polkinghorne (2005:138) also mentions the fact that a qualitative inquiry is designed to study the “experiential life of people” with one of the primary purposes of qualitative research being “to describe and clarify experience as it is lived and constituted in awareness”.

A qualitative research project begins with the formulation of a “what” and/or “how” type research question, derived from the identified problem to be answered through the study’s research findings and conclusions (Lichtman, 2014:30; Hennink et al., 2011:33). In qualitative research, the idea of an emergent and flexible research design is accommodated (Creswell, 2014:186; Mathani, 2004:58) and the qualitative research design is thought of as a “rough sketch”, rather than an “exact blueprint” (Frankel & Devers, 2000:253), implying that the qualitative research design is to a larger extent a “do-it-yourself” rather than an “off-the-shelf” process (Maxwell,

2013:3). Data is typically collected in the participants' setting with the researcher in most cases being the main instrument of data collection (Creswell, 2016:6; Creswell, 2014:4, 43). An inductive approach is followed in analysing the qualitative data in that the raw data collected is used to develop themes that will eventually lead to a comprehensive understanding of the phenomenon being investigated (Merriam & Tisdell, 2016:17). In qualitative research, the final written report has a flexible structure (Creswell, 2014:4).

In summary, at the heart of qualitative research lies a topic to be explored and, according to Creswell (2016:6-9), the following elements depict the nature of qualitative research:

- Qualitative research aims to lift up and report the voices of marginalised groups or populations by exploring sensitive topics in an open-ended way.
- The qualitative researcher goes out to the setting (or context) to collect data from a small number of people, by looking at how processes unfold in an attempt to develop a comprehensive understanding and multiple perspectives or views on the phenomenon being investigated.

Given the nature of qualitative research as introduced in the preceding paragraphs, and the research questions and goals formulated for the study (see Section 2.2 and 2.3), I decided to employ a **qualitative research approach**, as it would contribute towards my understanding of the experiences and needs of TSs presenting with UPs and/or TOPs, as well as their expectations in terms of support in this regard. In addition, it would allow for an exploration of SPs' perceptions of TSs' experiences and needs related to UPs and TOPs, as well as the scopes of the support services they offer to the said students. Furthermore, it would provide me with an opportunity to request suggestions on how TSs confronted with UPs and/or TOPs could be supported in view of the formulation of practice guidelines for psychosocial support to such students.

2.4.2 Research design

In writing about the aspect of the research design in qualitative research, Maxwell (2013:3) notes that one cannot develop or borrow a logical strategy in advance and then implement it rigidly. One will have to construct and reconstruct the research design as the study proceeds, by “tracking back and forth between the different components of the design, assessing their implications for one another” because the “design... must fit not only its use, but also its environment” (Maxwell, 2013:3). In view of this, Frankel and Devers (2000:253) advise qualitative researchers to think of a qualitative research design as “a rough sketch” that will become more detailed as the study progresses. Contained in such a sketch will be guidelines and instructions to be followed flexibly in order to address the research problem and assist with the process of determining the research decisions to be taken so as to maximise the trustworthiness of the eventual results (Mouton, 2009:107). In essence, the research design serves as outline for how the research project will proceed (Monette, Sullivan & De Jong, 2011:506). Flick (2015:81) states that in qualitative research, the use of the term “research design” refers to:

...planning of the study: how to plan the data collection and analysis and how to select the empirical material (situations, cases, individuals etcetera) in order to be able to answer the research question in the available time and with the available resources.

In an attempt to remain true to the qualitative research approach intended for the study, I decided to employ the case study design, specifically the collective instrumental case study design, and the phenomenological research design, regarded as qualitative research designs or sometimes even referred to as “approaches” or “strategies of inquiry” (Lichtman 2014:99; Creswell, Hanson & Plano Clark, 2007:238, 240). In addition, an explorative, descriptive, and contextual strategy of inquiry will be adopted, as the research objectives for this study (and that of qualitative research) are to explore and describe the phenomenon being investigated (Creswell, 2016:7; Babbie, 2010:17). I endeavoured to explore and describe the experiences and needs of TSs presenting with UPs and/or TOPs, as well as their support needs and the support they had received to date. In addition, I planned to explore and describe how

SPs who render support services to TSs with UPs and/or TOPs perceived the experiences and support needs of these students, as well as the scopes of the services they offer to such TSs. Furthermore, my intention was to gather suggestions from both the service users (namely TSs) and the SPs on how students presenting with UPs and/or TOPs could be supported in view of formulating practice guidelines for psychosocial support directed at SPs offering support to TSs with UPs and TOPs.

The mentioned designs will now be introduced.

2.4.2.1 The collective instrumental case study design

In explaining the case study as qualitative strategy of inquiry, Creswell et al. (2007:245) note that in case study research, the researcher, by way of detailed and in-depth data collection, engages multiple sources and explores a case(s) within a bounded system(s) – in other words, a setting or a context (cf. Creswell 2014:14; Wahyuni 2012:72). The primary purpose of case study research according to Simons (in Thomas, 2016:10) is “to generate in-depth understanding of a specific topic... to generate knowledge and/or inform policy development, professional practice and civil or community action.”

In this research, I planned to employ a collective instrumental case study design and for this reason the concepts “collective case study” and “instrumental” need to be explained. When a researcher aims to investigate a phenomenon from the perspectives of multiple cases, it is called a “multiple case study” or a “collective case study design” (Creswell & Poth, 2017:99; Thomas, 2016:172; Creswell et al., 2007:236; Stake, 2005:445). The concept “instrumental” in the collective instrumental case study points to the fact that the case study is done with a specific purpose in mind; it is proverbially acting as an instrument – a tool – to provide insight into an issue based on a research question or a need for general understanding (Creswell & Poth, 2017:98), or to assist with the refinement of a theory (Thomas, 2016:121; Snow, Wolff, Hudspeth & Etheridge, 2009:244). As my intention was to explore the topic

under investigation from the vantage points of sampled TS and SP-participants, with the aim of gaining insight into the experiences, support, and support needs of TSs who had an UP and/or a TOP, and to request suggestions in view of formulating practice guidelines for use by SPs to provide psychosocial support, the collective case study design, to be instrumentally employed, displayed the potential to be utilised in this research endeavour.

2.4.2.2 The phenomenological research design

In addition to the collective instrumental case study design, I also planned to include a phenomenological research design as part of the strategy of inquiry. This decision was informed by the fact that I wanted to explore and describe in particular the TSs' lived experiences in relation to their UPs and/or TOPs. Phenomenology seemed to be fitting for this purpose, as phenomenology is the study of "phenomena as they present themselves in individuals' direct awareness and experiences" (O'Leary, 2017:149) or their lived experiences (Yates & Leggett, 2016:229), or when a researcher wants to find out what a particular experience means to a particular group of people (Grossoehme, 2014:117). Creswell (2016:262-263) emphasises the following aspects when employing the qualitative research design as a strategy of inquiry: The researcher –

- focuses on the exploration of a single phenomenon, namely UPs and/or TOPs;
- collects data from individuals who have experienced the phenomenon;
- explores the context in which the individuals experience the phenomenon, namely higher education;
- brackets out personal experiences, since the focus is on how the participant experiences the phenomenon; and
- reports on the essence of the experience by way of a rich, authentic, and detailed word-picture.

The way in which I intended to employ the phenomenology as the strategy of inquiry in this study relates to what Moustakas (in Creswell & Poth, 2017:78) coined as

“transcendental phenomenology”. The process of transcendental phenomenology, according to Moustakas (in Creswell & Poth 2017:78), corresponds with the above-mentioned aspects and comprises exploring the phenomenon to be investigated, putting one’s own knowledge and experience in abeyance, and interviewing participants who experienced the phenomenon. In so doing, one sees the phenomenon “freshly, as for the first time” and is open to its totality (Moustakas, in Moerer-Urdahl & Creswell, 2004:21). The data is thematically analysed and underscored by quotations to substantiate the themes in order to produce a textural description of the participants’ experiences.

2.4.2.3 *The explorative, descriptive, and contextual strategy of inquiry*

In view of the research objectives of exploring and describing (1) TSs’ experiences, support, and support needs in relation to their UPs and/or TOPs, and their suggestions for support (professionally and informally), and (2) SPs’ perceptions of TSs’ experiences and support needs related UPs and TOPs, as well as (3) the scope of support services offered by SPs to TSs presenting with UPs and/or TOPs, I planned to also include an explorative, descriptive, and contextual strategy of inquiry.

Creswell (2016:7) asserts that “qualitative research is exploratory research”. *Exploratory research* is undertaken when problems have been identified, but our understanding of them is inadequate (Babbie, 2010:67). This type of research begins the process of building knowledge about a problem and/or question and it investigates a phenomenon where little knowledge exists or where the state of research and theoretical literature are not sufficiently developed (Flick, 2015:111; Neuman, 2012:73; Babbie & Mouton, 2007:79).

Apart from the research objectives pointing to the need to incorporate the explorative research design as part of the strategy of inquiry, a stillness in the literature regarding practice guidelines for psychosocial support from the ambit of social work directed at SPs (and informed by suggestions from both students and SPs in this regard) to

respond to the needs of TSs presenting with an UP and/or a TOP, necessitate explorative research to be conducted.

Considering the fact that qualitative research is essentially exploratory, the outcome of such exploration is to describe, understand, and explain a particular phenomenon (Barbour, 2000:156). For this reason, I intended to employ a *descriptive strategy of inquiry* as part of the research design for this study, as it would provide me with an opportunity to, with intense accuracy, view and consider the phenomenon of the moment (Leedy & Ormrod, 2005:134). Principally, qualitative research is descriptive (Mathani, 2004:57), with the purpose of description being threefold: to reveal the concepts and complex pattern of relationships between the concepts observed; to disclose the intricacies surrounding the phenomenon; and to explain why things happen as they do (Mathani, 2004:57).

I therefore set out to describe the explored experiences and needs of TSs who have had an UP and/or a TOP, as well as their suggestions for support to TSs in a same predicament. It was also my intention to provide a word picture of the SPs' perceptions of the experiences and needs of the mentioned students, as well as the scopes of the support services offered to these students by the providers. Their suggestions to support such TSs will also be described.

Contextual research seeks to avoid the separation of participants from the larger context to which they may be related (Neuman, 2012:92; Shaw & Gould, 2001:17). This is especially true in qualitative research, which emphasises holism and everyday life (Babbie, 2010:68-69) and where the aspect of "contextual" research implies that the significance of human creations, words, actions and experiences can only be determined in relation to the contexts in which they occur (Terre Blanche et al., 2006:274).

I proposed to explore the experiences and needs of the relevant interest groups, as well as the scopes of support services rendered by SPs to students with UPs and/or TOPs, within the context of higher education.

Informed by the outcome of the empirical or field research, a literature review relating to the phenomena of UPs and TOPs, as well as information in the literature on the legislative and policy frameworks available to guide the provision of psychosocial support to women presenting with UPs and/or TOPs, I proposed to formulate practice guidelines for psychosocial support aimed at SPs rendering support services to TSs with UPs and/or TOPs.

2.5 RESEARCH METHODS

The practical activities proposed for this research project in terms of sampling, data collection, data analysis, and data verification will now be presented (Wahyuni, 2012:72; Carter & Little, 2007:1318).

2.5.1 Population, sample, and sampling techniques

The concept “population” in the context of research refers to an entire group of persons, objects, or events of interest to the researcher (Neuman, 2012:146; Fox & Bayat, 2007:52). Punch (2016:175) elaborates on the explanation of this concept when stating that the population of a study refers to “the target group, usually large, about whom we want to develop knowledge, but which we cannot study directly; therefore we sample from the population.” The importance of clearly defining a population is emphasised by both Babbie (2010:193) and Potter (2002:47), who state that the population should be focussed on a geographically demarcated area and that the characteristics of the population should reflect the concern of the phenomenon under investigation. According to the mentioned authors, this will inform the researcher about *who* to recruit and *how* to recruit (cf. Hennink et al., 2011:85-87).

The aim of the research thus provides direction on who will be sampled from the population for inclusion in the study (Coyne, in Koerber & McMichael, 2008:464). With this directive in mind and after revisiting the goals of the study (see Section 2.3), I decided to identify two populations for the study, namely:

- All TSs, enrolled at one of the four identified tertiary institutions in Gauteng, who have experienced an UP and/or a TOP.
- All SPs, such as volunteer counsellors, healthcare professionals, social workers, and psychologists, who have rendered support services to students with UPs and/or TOPs at these tertiary institutions in Gauteng.

I decided to delimit the population to tertiary institutions and SPs in Gauteng. My motivation for this decision was based on the fact that I reside in Pretoria (Tshwane), Gauteng, and deemed this decision to be the most effective, time- and cost-wise.

Prior to finally demarcating the boundaries of the population, I intended to make contact with SPs rendering services, such as counselling/therapeutic support, preventative services, and psycho-education, to TSs at various tertiary institutions in Gauteng. The purpose of this was to informally ascertain the prevalence of and significant increase in UPs and TOPs amongst TSs, and the need for practice guidelines for psychosocial support directed at SPs to address the students' presenting problems, as well as their willingness to participate in the research.

Financial and time constraints, the sensitive nature of the topic under investigation, as well as the fact that I intended to include two population groups in this study made it impossible to study every case which was of interest to me (Neuman, 2012:146; Becker, in Silverman, 2005:136; Alston & Bowles, 2003:81-82), which resulted in me having to choose a sample from the populations of interest.

Sampling or participant recruitment (as it is commonly referred to in qualitative research) is defined as the process of selecting participants from the populations to take part in a research study in order to study the phenomenon under investigation

(Neuman, 2012:146; Monette et al., 2011:506; Hennink et al., 2011:84; Creswell, 2007:128).

Two major categories of sampling exist, namely non-probability and probability sampling, with the latter referring to sampling in which each unit of analysis of the population has an equal chance to be selected. This form of sampling is usually used in quantitative research processes. Non-probability sampling, on the other hand, is generally used in exploratory research by qualitative researchers (Creswell & Poth, 2017:158). It is inclusive of four types of sampling, namely accidental, purposive, snowball, and quota sampling (Babbie, 2010:193; Alston & Bowles, 2003:87), as qualitative researchers seek to gain an understanding of the meaning of a phenomenon from the participant's viewpoint (Hennink et al., 2011:85). The above-mentioned authors further state that non-probability sampling is of particular use and value when a researcher is interested in information that is new or under-researched and from the vantage point of the participants who typify the issue under investigation.

Hence, *purposive sampling* was decided on as strategy for participant recruitment in this study, as this method would enable me to deliberately select participants whom I deemed suitable for providing detailed information about the phenomenon under study (Creswell, 2016:109; Merriam & Tisdell, 2016:96). I furthermore believed that the openness and flexibility that characterise purposive sampling (Flick, 2007:27) would allow me to seek out information-rich cases, in fact, hand-pick them, by virtue of their intimate knowledge of and ability to communicate about the phenomenon under study, so as to learn about issues of central importance to the aim of the inquiry (Reybold, Lammert & Stribling, 2012:702-703; Patton, 2002:230; Sandelowski, 1999:81).

In planning to obtain a sample, from the identified populations mentioned above, I decided to recruit participants by using criteria of inclusion. Using inclusion/exclusion criteria for participant recruitment is a common practice in qualitative research, with

purposive sampling traditionally being based on criteria that the investigator establishes at the outset, with the purpose of ensuring that information-rich participants are hand-picked and that participant characteristics account for methodological rigour (Grossoehme, 2014:112; Suri, 2011:69). In Table 2.2 below, an exposition is provided of the *inclusion criteria* proposed to purposively select participants from the identified populations in order to identify their concerns.

Table 2.2: Criteria of inclusion for selecting information-rich participants from the identified populations

Inclusion criteria proposed to recruit a sample of TSs	<p>Students –</p> <ul style="list-style-type: none"> ✓ both day and residence students; ✓ of all ages and race groups; ✓ enrolled at any of the four participating tertiary institutions in the Gauteng Province; ✓ who have made an appointment with or requested support/assistance from a SP in relation to an UP and/or a TOP.
Inclusion criteria proposed to recruit a sample of SPs who render support services to TSs presenting with an UP and/or who have had a TOP	<p>SPs with reference to –</p> <ul style="list-style-type: none"> ✓ Social workers, psychologists, and healthcare professionals employed at any of the four participating tertiary institutions in Gauteng, rendering support services to TSs with UPs and/or students who have terminated their pregnancies. ✓ Volunteer counsellors at the satellite office of a CPCC that was established on one of the campuses of a participating tertiary institution, rendering support services to TSs with UPs and/or students who have terminated their pregnancies ✓ Volunteer counsellors at the head office of said CPCC in Pretoria (Tshwane), rendering support services to TSs with UPs and/or students who have terminated their pregnancies.

Unlike quantitative research, where sample size is determined at the outset by way of statistical formulas dictating the number of subjects to ensure the generalisation of the findings to the population studied (Koerber & McMichael, 2008:467), the principle of data saturation determines the sample size in qualitative research. Seeing that the quality and depth of information, and the variation in experiences of recruited participants are of particular interest in qualitative research, a large number of participants are seen as “impractical and non-beneficial” (Hennink et al., 2011:88). Fossey, Harvey, McDermott and Davidson (2002:726) state the following with regard to data saturation informing the eventual sample size:

...sampling in qualitative research continues until themes emerging from the research are fully developed, in the sense that diverse instances have been explored, and further sampling is redundant. In other words, patterns are recurring or no new information emerges.

Hennink et al. (2011:88) add to this by confirming that saturation is “simply the point at which the information one collect begins to repeat itself”. Taking the aforementioned scholarly opinions into consideration and because of the qualitative nature of this research endeavour, the sample size for this study was to be determined by data saturation.

2.5.2 Recruitment, screening, selection of participants, and preparation for data collection

The importance of researchers being thoroughly prepared before embarking on the process of entering the field to recruit, screen, and select participants and prepare them for participation in data collection is emphasised by several scholars (Rossman & Rallis, 2012:146; Morrow, 2007:12; Donalek & Soldwisch, 2004:354; Feldman, Bell & Berger, 2003:19). Establishing contact and a rapport with potential participants (by getting to know them and maintaining relationships with them once they have been selected for participation) are prerequisites preceding the process of data collection (Babbie, 2014:126; Rossman & Rallis, 2012:146; Feldman et al., 2003:19; Devers & Frankel, 2000:3). The relationship between the researcher and the participants, characterised by warmth, openness, and mutual trust, is said to be conducive for improving and ensuring rigorous research findings (Babbie, 2014:325; Rossman & Rallis, 2012:156). This preparatory process furthermore includes and refers to the careful and comprehensive design of interview guides in view of data collection after the recruitment of suitable participants, once they have been adequately informed of the purpose of the research and their involvement in the research, and agreed to participate voluntarily.

The focus of the discussion now shifts to a description of the procedure that I proposed to adopt in order to identify, recruit, and prepare the participants for data collection.

Prior to embarking on this research journey, I had to obtain ethical approval and clearance for her proposed study from the Department of Social Work's Research and Ethics Committee at UNISA, where I was registered for my doctorate studies. I submitted an abridged version of the research plan presented in this chapter for that purpose.

Once approval was obtained, my plan, prior to the identification and involvement of the research populations through sampling participants from the populations (discussed in Section 2.5.1 above), was to establish contact with several SPs (social workers, psychologists, and healthcare professionals) at various tertiary institutions in Gauteng, as well as volunteer counsellors at the CPCC. Some of them were already known to me as colleagues who, like me, were offering counselling and support services to registered students at their respective tertiary institutions. Even before embarking on this research project, I engaged in telephone interviews with them, to enquire about the prevalence of UPs and/or TOPs at their respective universities and to get clarity on the feasibility of my research undertaking, specifically to ultimately formulate practice guidelines for psychosocial support (the information obtained from them in this regard is incorporated in Chapter One of this thesis as part of the introduction and motivation for this study).

The aim of my contact with the SPs from the various tertiary institutions and the CPCC, once I had been granted ethical approval to conduct the study, was to gather information on who I should approach, what would be required of me to officially apply for permission to conduct research at these settings, and for them to allow me access or arrange access to possible research participants. In essence, this initial contact was to familiarise myself with the protocol and logistics for gaining access to each site with the purpose of conducting research, to determine the requirements to obtain

ethical clearance from the respective authorities, and also to strengthen existing and establish new collaborative relationships and research partnerships. In addition, my strategy was also to ascertain, through this contact with the SPs, their willingness to act as gatekeepers and to identify other gatekeepers (Rossman & Rallis, 2012:161; Yin, 2011:144). Gatekeepers, in the context of research, are individuals at research sites who regulate or provide access to the site and allow or permit a qualitative research study to be undertaken (Creswell & Poth 2017:320; Creswell, 2013:231; Creswell, 2009:178; 229). A gatekeeper can be a community leader, a local SP, a religious or political leader, or any other type of person who has the ability to provide access to the community of interest (Hennink et al., 2011:93). Neuman (2003:338; 2012:294) adds to this description by stating that a gatekeeper is someone with the formal and/or informal authority to control access to a site. Aside from regulating or providing access, gatekeepers can provide important information about community networks, organisations, or avenues for participant recruitment, as they generally have a prominent and recognised role in the community (Hennink et al., 2011:95-96) and are able to influence and encourage community members to participate in a research study.

I considered this contact with my fellow SP colleagues and their willingness to act as gatekeepers, should they be identified by the representatives of their respective institutions to do so, as an important part of my process of gaining entry to and cooperation from settings, as their permission and a “buy-in” to conduct the research study would be of particular importance with regard to access to the research sites and potential participants.

Equipped with the information gathered from my fellow SP colleagues, the following steps proposed would be implemented:

- **Announcing the research project and obtaining ethical clearance to conduct the research at the various sites**

A letter (see Annexure A) explaining the purpose of the research and requesting permission and ethical clearance to conduct research at the identified research sites (namely four tertiary institutions in Gauteng as well as a CPCC in Pretoria, Tshwane) would be sent to the relevant deans, heads of departments (HODs) (from the research and ethics committees/departments, student counselling, and campus clinics/health departments of the specific institutions) and directors/managers. Once the necessary ethical clearance and permissions from the relevant bodies at the four tertiary institutions and the CPCC were obtained²⁴, I planned to enquire who I should contact to act as gatekeepers or who the contact persons would be to assist me by putting me in contact with or identifying possible participants. I was aware of the fact that I could be referred back to the SPs that I initially contacted, or other gatekeepers who could bring me into contact with more SPs.

- **Establishing contact with gatekeepers in view of them assisting with possible TS-participants and to also request their participation in this research project**

Follow-up contact (telephone calls, correspondence, and/or in-person meetings) would be made with the contact persons that would be indicated on the ethical approval letters received from the various institutions. The intended purpose of this contact was to get the particulars of the gatekeepers (SPs rendering support services to TSs at the different fieldwork settings). Once the gatekeepers were identified, contact would be established with them and meetings held with them at

²⁴ A synopsis of the application of this proposed process, namely gathering information about the prevalence of the topic intended for investigation; gaining information about the setting; the logistics and protocols that had to be followed in order to obtain permission and ethical clearance to conduct the research; as well as the process that was applied to access the fieldwork sites and research participants, such as the identification of gatekeepers, etc., is presented in Section 3.5.2.1 to 3.5.2.3, and Figure 3.1.

each of the fieldwork settings (the participating tertiary institutions and the CPCC). I intended to pursue the following objectives at these meetings:

- The SPs would be requested to participate in the study as gatekeepers, and be informed about what this role would entail. In essence, they would be requested to assist in identifying and facilitating access to possible TS-participants. Should they be willing to take on this role, the SPs, who would be able to identify TSs or know about students who match the criterion of being a student who had experienced an UP and/or a TOP, would also be tasked to extend a written invitation (see Annexure B) to such TSs on my behalf to inform them about the research project and request that they consider participating. Emphasis would be placed on the importance of the role of the gatekeepers as referral sources, as I did not have direct access to the TSs.
- Aside from acting as gatekeepers and in this regard assisting with the recruitment of potential TS-participants, the SPs would also be invited, officially, by means of a written letter (see Annexure C), to consider participating in the research study. Whilst a detailed explanation of the purpose of the study, the inclusion criteria, and method of data collection would be provided during the telephone calls/correspondence/in-person meetings with the SPs, the formal written letter of invitation was deemed ethically appropriate so as to inform them verbally and in writing about the purpose, logistics, and their participation in this research to assist them to make an informed decision whether or not to participate. During the mentioned meetings with the SPs, they would be granted an opportunity to ask questions about the research project. They would be given two weeks to consider whether or not they would want to participate.

The willingness of the SPs to participate in the research study would be established by means of follow-up telephone calls and e-mail correspondence,

after which appointments with the willing participants would be made in preparation for data collection and to collect the data. The intended plan was for the latter to be done by means focus group discussions, to be conducted per institution/organisation. I acknowledged that this might have posed a possible limitation (namely possible peer group influence when a focus group discussion is conducted with the same group of people, employed in a similar context, at the same institution/organisation), but according to Alston and Bowles (2003:120) and Greeff (in De Vos, Strydom, Fouché & Delport, 2011:361-362), the advantage thereof is that it is perceived to be a time and cost-effective method of data collection. Furthermore, the purpose of the study was not to evaluate the service delivery of the SPs, but to gain insight into their perceptions of the experiences and needs of TSs presenting with UPs and/or TOPs and the scopes of support services offered by them to said students. The decision to conduct the focus group discussions with SPs per institution/organisation would enable me to observe specific operational trends and modus operandi at each of these settings which I deemed relevant with regard to the formulation of practice guidelines for psychosocial support. Prior to participating in a focus group discussion, the relevant informed consent form (see Annexure E) had to be completed by the SP members participating in the focus group, testifying to their voluntary, willing participation and confirming that they have been comprehensively informed about the research. The signing of this document would form part of the appointments where they would be prepared for data collection prior to the actual focus group discussions.

- **Establishing contact with possible TS-participants**

I intended to contact the TSs who expressed an interest to participate in the research upon coming to know about this endeavour after they granted the gatekeepers permission (who took on the task of identifying possible participants and informing them about the research verbally and in writing – see Annexure B) to forward their identifying particulars and contact details to me. It was

envisaged that the latter would be supplied to me in writing via the declaration sheet (requesting the potential TS-participants to confirm their interest in participating and noting their contact details) attached to the mentioned invitation (cf. Annexure B). During this initial telephonic contact, the following aspects would be covered. As planned, I intended to –

- thank them for their interest in and willingness to participate in the research project, and confirm whether they met the criteria stated to qualify them to participate in this study;
- discuss the content of the written invitation (see Annexure B), which included the purpose and the procedures of the research, their role, rights and responsibilities, the potential risks and benefits involved in participating, as well as the ethical considerations (anonymity and confidentiality) that I planned to observe during the study;
- explain the proposed method of data collection, namely an in-depth, semi-structured, face-to-face interview, and invite each student to write a letter to be submitted within one month after the interview, as an additional opportunity to share, add, or reflect on any other information related to their experience of UPs and/or TOPs;
- give the potential participants an opportunity to clarify any issues and ask any questions related to the invitation to participate and/or the research study itself;
- ascertain their willingness to still participate after having received all the information verbally and in writing; and
- make an appointment with each student to sign the informed consent document (see Annexure D) and to collect the data. The day and time of this appointment would be communicated to the TSs still willing to participate, once the gatekeepers had secured a safe, comfortable, and private venue where the data collection could be conducted. The date and time of the venue would also be determined by each TS individually.

The next section consists of a presentation of the methods proposed for collecting data from the sampled participants.

2.5.3 Methods of data collection

Data collection, by way of employing different data collection methods, is a process of discovery aiming to assist the researcher in identifying the concerns of the populations; uncovering aspects of the participants' reality; gaining an understanding into the research problem identified; and providing the answers to the research questions formulated at the outset of the study (Rossman & Rallis, 2012:168-169; Grinnell & Unrau, 2011:562).

As stated earlier in this chapter (see Section 2.4.1), I intended to follow a qualitative research approach in this study. While several scholars aver that in-depth interviews, participant observation, and focus group discussions are the most commonly used methods in qualitative inquiries (Guest, Namey & Mitchell 2013:5; Lichtman 2014:241; Rossman & Rallis 2012:168), the methods of data collection ultimately decided on are determined by the research question, the sensitivity of the phenomenon under investigation, and the available resources (Rossman & Rallis, 2012:168-169; Grinnell & Unrau, 2011:562).

Given the sensitive nature of the topic, especially with regard to my request that the TSs reflect on and speak about their UPs and/or TOPs, and Liamputtong's viewpoint (in Dempsey, Dowling, Larkin & Murphy, 2016:480) that in-depth, face-to-face interviews are an ideal method of data collection when exploring sensitive topics (see also Hesse-Biber & Leavy, in Hennink et al., 2011:109-110), I proposed to conduct **in-depth, semi-structured, face-to-face interviews**, facilitated by questions contained in an interview guide (see Annexure F).

In addition, and as the aim of the study was to phenomenologically explore the experiences, support, and support needs of those that have first-hand experience

(namely TSs) of the phenomenon of interest (an UP and/or a TOP), in-depth interviews, semi-structured in nature, are suggested as the method of data collection (Usher & Jackson, 2014:188). The aim in using interviewing as qualitative data collection method is to invite participants to share their perspectives, stories, and experiences regarding the topic under investigation (Wahyuni, 2012:73). In-depth interviewing is regarded as “a meaning-making partnership” as well as a “knowledge-producing conversation” between an interviewer and participant (Hesse-Biber & Leavy, in Hennink et al., 2011:109, 110). This type of interview is a “one-on-one method of data collection”, aiming to understand the participants’ social world and gain insight into and information on their personal experiences as it relates to a specific issue (Hennink et al., 2011:110; Mack, Woodsong, Macqueen, Guest & Namey, 2005:30; Heath 2004:277). With reference to the semi-structured nature of the in-depth interview, D’Cruz and Jones (2014:112) write: “While there is some structure, the interaction relies on a non-directional style because the topics covered are a guide and not a set of questions asked exactly in the same way for each participant.” Before in-depth interviewing can materialise, the establishment of a trust relationship between the researcher and the participant must take place. Questions contained in an interview guide directed at the participants are asked in a neutral manner with empathy, and the researcher uses probes and follow-up questions in order to encourage participants to share their experiences/stories (Hennink 2011:109; Mack et al., 2005:29). The particular value and use of in-depth interviews are found in the insight and knowledge that they provide about the perspectives, feelings, opinions, and experiences of individuals (Mack et al., 2005:30).

Apart from the in-depth interview facilitating an exploration of the personal stories of participants, it also enables the researcher to uncover the background characteristics influencing the participants’ stories. It furthermore assists the researcher with identifying the economic, physical, social, and cultural context in which the participants live and function (Wengraf, 2001 in Hennink et al., 2011:110). The strengths and limitations of in-depth interviews are depicted in Table 2.3 below.

Table 2.3: A tabulated overview of the strengths and limitations of in-depth interviews

Strengths	Limitations
Elicits in-depth responses, with nuances and contradictions.	As this is a one-on-one interview, there is no feedback from others.
Elicits information on people's personal experiences, emotions, and narratives.	Special skills are needed (for establishing a rapport, using motivational probes, as well as listening skills).
Useful for addressing sensitive topics.	Flexibility is needed (for example, the researcher might have to change the topic order in the interview guide in order to follow the participant's story).
Elicits useful contextual information regarding participants.	In-depth interviews result in a lot of transcription.
Elicits interpretations (in other words, the connections and relationships between specific events, phenomena, or beliefs).	

Adapted from: Hennink et al. (2011:109 & 131)

With reference to the interview guide containing open-ended questions used to facilitate the in-depth interview, Hennink et al. (2011:112) emphasise that this should not be confused with a questionnaire (as in quantitative research). The interview guide consists of a list of questions, usually designed before the actual process of data collection (Creswell, 2007:133). The purpose of an interview guide is to guide the researcher in the interviewing and it is used by the researcher, "mainly as a memory aide during the interview" (Hennink et al., 2011:112; Sewell, n.d.:4). It furthermore is semi-structured, specifically when an exploratory study is conducted. It typically consists of an introduction, opening questions, key questions, and closing questions (Hennink et al., 2011:119; Mack et al., 2005:34). The interview guide therefore serves as a research tool that guides the interview; it provides focus, yet still allows for flexibility (Fossey et al., 2002:727).

However, the researcher has to note that when employing phenomenology as strategy of inquiry, having an interview guide with a list of questions to facilitate the proses of gaining insight into the phenomenon under investigation is not a fait accompli. Chan, Fung and Chien (2013:4) point out that a researcher engaged in a descriptive phenomenological study should not opt for a predetermined set of questions, but should formulate questions in response to the cues and information

shared by the participants – a point of view also shared by Englander (2012:26). The central criterion in a phenomenological interview according to Giorgi, quoted in Englander (2012:27), is that “what one seeks from a research interview in phenomenological research is as complete a description as possible of the experience that a participant has lived through.”

Englander (2012:26) advocates for an opening (central) question, for example: *“Please describe to me, in as detailed a manner as possible, your situation when you experienced your UP and/or TOP?”* The remaining questions should flow from the response of the interviewee, focusing on the phenomenon being investigated.

Whilst both Chan et al. (2013:4) and Englander (2012:26) declare their view on not having predetermined questions, apart from the central question, when incorporating phenomenology as the strategy of inquiry, they both make leeway for more questions. As a result of this, the nature of the phenomenological interview turns from unstructured to semi-structured (Englander, 2012:26). Chan et al. (2013:4) defend their allowance in this regard as a precautionary measure to prevent (especially) novice researchers from posing leading questions. In addition, such questions are merely to be used to guide and not lead the participant, allowing the researcher the freedom to further probe what the participant shares (Chan et al., 2013:4). For this study, I decided to follow the route of having an interview guide with open-ended questions (see Annexure F), remaining conscious of the fact that they are there to guide the interview and to be used for probing.

In order to obtain biographical information from the TS-participants recruited; I intended to direct the following questions to them (cf. Annexure F):

- How old are you?
- What course of study are you enrolled for?
- For which year of study are you currently registered?
- Where are you residing (university accommodation such as a residence or commune; or private accommodation such as a flat)?

- In which province do you live when not at university?
- How would you describe the area you grew up in (urban, semi-urban, rural)?

In order to gather information about the topic under investigation, I planned to direct the following requests and questions to the TS-participants.

Opening request: Please describe to me, in as detailed a manner as possible, your situation when you experienced your UP.

Further probing requests and questions:

- What would you say were the reasons for your UP?
- Share with me what your personal circumstances were at the time of your UP?
- Think back and share with me the feelings/emotions that you experienced when you realised that you were pregnant.

Follow-up central request 1: Please share with me how the UP that you have experienced changed your life.

Follow-up central request 2: Share with me how you dealt with your UP.

Further probing requests and questions in response to the second follow-up central request:

- Tell me about the factors that influenced the decision that you have taken in order to deal with your UP.
- What feelings/emotions did you experience as a result of your decision taken to deal with your UP?

Follow-up central request 3: Please tell me about the types of support that you received in relation to your UP and/or TOP:

- a) on campus; and
- b) off campus.

Further requests and probing questions:

- Share with me how you experienced the support that you received.
- Looking back on the support that you received, what would you have liked to be different in terms thereof?

Follow up central request 4: Based on your experience as a TS who had an UP and/or a TOP, what suggestion(s) do you have on how students who present with an UP and/or TOP could/should be supported?

Certain relationship and communication skills are needed in order to conduct effective in-depth interviews, as these have an influence on the comprehensiveness and complexity of information provided by the participants (Hennink et al., 2011:123; Mack et al., 2005:38). Core skills required in this regard include building a rapport and creating a safe, comfortable environment for the participant (Lichtman, 2014:252); posing questions in an open, friendly, and non-judgemental way; observing the body language and reactions of the participant; and being able to adapt to different participant personalities and emotional states (Edwards & Holland, 2013:54). Expressing empathy with the participant's perspective and keeping track of the questions, while letting the conversation develop and flow naturally, are also seen as equally important (Edwards & Holland, 2013:77).

As in-depth interviews can be time-consuming and emotionally taxing on both the participant and the researcher, especially with sensitive topics (Dempsey et al., 2016:482), the researcher needs to be on the lookout for emotional upset, tiredness, boredom, impatience, or annoyance being exhibited by the participant and address it (Hennink et al., 2011:130; Mack et al., 2005:34).

Aside from planning to conduct in-depth, one-on-one interviews with the sampled TSs, I also intended to invite them to write a letter (addressed to me) to share any additional information (following the interview) they deemed relevant or important. This could include any information that was either not thought of during the interview,

or information the student did not feel comfortable sharing during the interview. An envelope, addressed to me, that would include writing paper and a postage stamp would be supplied to each participant at the end of each interview for this purpose, with the request to post the letter to me within one month of the interview. I would emphasise that writing such a letter would be strictly voluntary and that the purpose thereof would be to give each participant an opportunity to share, anonymously, additional information regarding her experience and/or support needs. It was envisaged that these letters would illuminate the deeper meaning that participants might attach to their experience (Ritchie & Lewis, 2003:35) and the content of these letters would enhance my understanding of and insight into the phenomenon; providing greater clarity, specifically with regard to the development of the proposed guidelines for psychosocial support.

To explore SPs' perceptions of TSs' experiences and support needs related to their UPs and/or TOPs to gain insight into their scopes of practice in rendering support services to the students concerned, and to generate suggestions from them in view of the formulation of practice guidelines for psychosocial support directed at SPs offering support services to TSs with UPs and/or TOP, I intended to employ **focus group discussions as the qualitative method of qualitative interviewing**.

Focus group discussions are described as a qualitative data collection method, used for exploratory, explanatory, evaluative, or policy-oriented research, in which a researcher and several participants meet as a group with the aim of gaining a broad range of views on a specific research topic (Guest et al., 2013:172; Hennink et al., 2011:136; Mack et al., 2005:51). Focus group discussions are particularly appropriate when a researcher wishes to explore new topics, gain a variety of views about the topic under investigation, and gain an understanding of typical behaviour in the interest group or an understanding of group processes (Lichtman, 2014:294; Hennink et al., 2011:138).

Similar to the in-depth interview, a focus group discussion can also be semi-structured in nature (Lichtman, 2014:293). The researcher may have a discussion guide comprising a list of topics or questions, but it is to be used in a flexible fashion to steer the focus group discussion (Hennink et al., 2011:141). Although there are similarities between the design of the questions for a focus group discussion and the questions designed for an in-depth interview, the major difference is found in the purpose of the questions of the focus group. With the focus group discussion in mind, the questions are designed for a group of people with the intention of stimulating and promoting a discussion. These questions furthermore have distinguishing characteristics, such as being open-ended, short, simple, and clearly formulated, without jargon, in a conversational but non-personal manner (Hennink et al., 2011:147).

According to Acocella (2012:1127) and Terre Blanche et al. (2006:304), focus group discussions as a method of data collection have the following disadvantages:

- The researcher has less control than when conducting individual interviews.
- It might be difficult to recruit people that meet the criteria.
- Confidentiality may become an issue, especially when sensitive issues are discussed. This can also result in participants feeling too threatened to reveal their honest opinions.
- It might be difficult to assemble participants at a specific place and time.
- Data can be relatively difficult to analyse.

Focus group discussions, however, also have several advantages. They elicit large volumes of information from a broad range of perspectives (Lichtman, 2014:293; Hennink et al., 2011:165; Mack et al., 2005:52). Participants are able to discuss the issues in question with each other. The exploration of an issue in a group context in turn may lead to a deeper understanding of the problem under investigation. Multiple viewpoints can be obtained and shared experiences can form a platform for discussion. The use of focus groups is also time and cost-effective (Lichtman, 2014:293; Leedy & Ormrod, 2005:146). Focus group discussions furthermore provide

an opportunity for participants to learn from each other and may allow them “to resolve important dilemmas with which they are confronted” (Bless, Higson-Smith & Kagee, 2011:118). However, the aforementioned authors emphasise the importance of a skilled facilitator for conducting the group and managing group dynamics.

After careful consideration of the mentioned disadvantages and advantages, I decided that the strengths of this method of data collection outweighs the weaknesses thereof and that focus group discussions as method of data collection would be appropriate for utilisation with the SPs. It would provide this participant group with an opportunity to share and describe their views, perspectives, and experiences, which would in turn enable me to identify their concerns and answer the research questions.

In order to obtain biographical information from the participating SPs, I intended to direct the following questions to them (see Annexure G):

- How old are you?
- What is your occupation?
- What is your highest qualification?
- How long have you been rendering support services to TSs, either in the field of higher education or as a volunteer counsellor?

In view of facilitating and stimulating the focus group discussion on the topic under investigation, I planned to direct the following questions to them (see Annexure G):

- What are your views in general about the phenomenon of UPs and TOPs amongst TSs?
- What are your perceptions on the experiences and support needs of TSs in relation to their UPs and TOPs?
- What are the scopes of the support services that you offer to TSs presenting with UPs and/or TOPs?

- Based on your experiences as SPs rendering support services to students presenting with UPs and/or TOPs, what suggestion(s) do you have on how these students can be supported by SPs in practice?

In order to effectively identify the concerns of the populations, through in-depth interviewing and focus group discussions respectively, I planned to apply the following **communication techniques** and **interviewing skills**:

- **Good appearance and demeanour:** social distances or differences between the researcher and research participants have been known to create suspicion and/or a lack of trust (Miller & Glassner, 2004:133). For this reason, I intended to dress appropriately in order to be seen as a part of the participants' worlds. For the interviews with the TSs, the intended plan was to dress more casually in order to make them feel comfortable and at ease. I planned to dress more formally for my interviews with the SPs.
- **Starting the interview:** participants would be engaged in marginal discussions and I intended to enquire about their general wellbeing and their academic/work schedule. I planned to start the interview by clearly explaining the purpose and format of the study, as well as asking a few demographic questions in order to help the participants to feel at ease.
- **Managing the interview:** Bearing in mind that this may have been the first time that some of the participants have ever participated in a research interview, I intended to formulate some ground rules (Guest et al., 2013:193) that I would focus on at the outset of the interviews and the focus group discussions. With reference to the latter, I would state that all views are welcomed; there will be no "right" or "wrong" answers; and they will be informed about what is expected from them, what their role would be, and how the group discussion would be conducted. The aspects of group member confidentiality would also be emphasised. Participants would be requested to switch their cellular phones off

for the duration of the interview (King & Horrocks, 2010:72). In explaining my role, I would make it clear that in this interviewer-interviewee partnership they would be regarded as the experts and that I would be the student; eager and willing to learn from and be informed by them. I also planned to emphasise and once again reiterate that participation in the interview or the focus group discussion is completely voluntary (Mack et al., 2005:40).

- **Open-ended questioning and requests:** I would be mindful to not ask more than one question at a time, and I would request that participants focus on only one central aspect at a time. I would ask for clarification when receiving vague or unclear responses. This request would be formulated along the following lines: “I’m not sure I understand... will you please explain to me what you meant when you said...?”. I would endeavour to use open-ended questions, such as: “Please share with me how the UP that you experienced changed your life.” Direct and indirect probes would be used, where and when necessary, for example “share with me the feelings/emotions that you experienced when you realised that you were pregnant?” I furthermore planned to, where appropriate, mirror what the participants said (Niewenhuis, in Maree, 2007:88) and I intended to employ summarising skills to tie thoughts shared together before shifting the focus to a next question and aspect.
- **Listening skills and non-verbal behaviour:** Mack et al. (2005:41) state that interviewers should always be aware of their body language, so as to not convey exasperation, boredom, prejudice, or strong emotions. In order to encourage participants to express themselves freely and to ensure that her non-verbal communication conveys openness, I would remain conscious of not crossing my arms or frowning, and I would exercise patience allowing participants to respond in their own time and style, whilst showing sincere interest.
- **Ending the interview:** Aside from planning to thank the participants for their time and contributions at the end of the data collection process (Feldman et al.,

2003:x), I planned to thank each participant via e-mail or text message. Participants would furthermore be reminded that they could contact me, should they require any further information or feedback related to the research study.

In order to capture the concerns of the sampled participants I intended to, with the permission of the participants, **digitally record both the interviews and the focus group discussions**. Although digital recording does have some disadvantages (for example, background noise can make recordings incomprehensible or the participant may not feel comfortable being recorded), a voice recorder allows for a much fuller record than notes taken during the interview, as it enables the researcher to concentrate on how the interview is proceeding and note all the relevant aspects of social processes (Kelly, in Terre Blanche et al., 2006:307).

Permission to record the interviews would be requested and obtained from all the participants, by asking them to sign informed consent forms (see Annexure D & E) to this effect. The digital recordings would be transcribed for data analysis purposes and the recordings and transcripts would be kept as evidence of the research. This would ensure that highly detailed and accessible representations of the interaction during the data collection process are obtained (Perakyla, 2004:325).

Apart from digitally recording the focus group discussions and the interviews, I also planned to employ **note taking during the data collection process** to ensure that any additional data obtained through the skill of observation would be recorded. Wahyuni (2012:74) distinguishes between three types of memos or notes that can be recorded for an interview. These are observational notes to describe what transpired during the interview; methodological notes, pointing to issues concerning the methods used (the type and style of questioning); and theoretical notes focussing specifically on possible themes emerging from the interviewing process.

By utilising the skill of observation, I intended to pay attention to non-verbal behaviour and, in the context of the focus group discussions, to specifically look at aspects such

as seating arrangements, communication patterns, and group dynamics. I would make an effort to limit the activity of making notes during the interviews so as to avoid disturbance, but concerted efforts would be made to complete my notes immediately after the interviews and the focus group discussions in an effort to produce a comprehensive account to complement and complete the data collection by the other methods of data collection (Whittaker 2012:4; Kelly, in Terre Blanche et al., 2006:307).

2.5.4 Pilot testing of the data collection methods and data collection instruments

A pilot test is encouraged and recommended as a review prior to commencing with the research procedure, with Yin (2011:37) stating that this could assist with the assessment and refinement of one or more aspects of the final procedure and that it affords the researcher the opportunity to appraise and reconsider the process planned for data collection.

It is impossible for a researcher to predict how interviewees might interpret the questions directed at them (Hennink et al., 2011:120). It is therefore suggested that the intended method(s) of data collection and the questions formulated in the interview guides be pilot tested (Wahyuni, 2012:74; Hennink et al., 2011:120; Yin, 2011:37).

A pilot study is described as a smaller version of the proposed study, with the aim to try out the method(s) of data collection in order to identify potential problems that could impact on the quality of the research results. If needs be, it is suggested that the methodology be refined (Grove et al., 2013:703). The findings of a pilot study are analysed to determine whether modification is required, or if it can be applied as is (Kumar, 2015:305). It is important to note that this information is not used in the main study. Pilot testing of the method(s) purely enables the researcher to assess any methodological risks and hindrances that might be encountered when the questions

are applied in the proposed study. Necessary adjustments are fine-tuned prior to the commencement of the proposed study.

The pilot study, as with the proposed study, involves the application of the same methodological procedures, as elaborated upon earlier in this chapter. I therefore planned to conduct an in-depth, semi-structured, face-to-face interview with a TS-participant, as well as a focus group discussion with a group of SPs. These interviews would, as per the intention with the proposed study, also be digitally recorded, transcribed, coded and analysed, after which I would assess if any of the findings serve as a guideline for refinement of the proposed methods of data collection.

2.5.5 Method of data analysis

Voluminous amounts of data are gathered through the qualitative methods of data collection, such as in-depth interviewing and focus group discussions, with such data needing to be transcribed and analysed in a managed fashion (Wu, Thompson, Aroian, McQuaid & Deatrick, 2016:499; Lichtman, 2014:318). Concerning analysing qualitative data, Wu et al. (2016:500) state: “During the analytic process, data are systematically transformed through identifying, defining, interpreting and describing findings that are meant to comprehensively describe the phenomenon” (see also Lichtman, 2014:318; Fossey et al., 2002:728). Analysis of the identified concerns as expressed by the populations point to an array of choices related to a researcher’s interaction with the data (Ravitch & Riggan, 2017:111). It entails a continuous process of looking for shared accounts about relationships and underlying themes. During this process, researchers continually move back and forth between initial and later interviews, identifying units of meaning whilst coding and interpreting the data as they go along (Grinnell & Unrau, 2008:388).

Through analysing the data collected through the in-depth interviews and the focus group discussions, my envisaged aim was to seek and capture the meanings and

relationships that participants attach to their life experiences, enabling inferences to be made (Desai & Potter, 2006:117).

I planned to analyse the collected data according to the step-wise framework for analysing qualitative generated data as proposed by Tesch (in Creswell, 2014:196). This process ensures a comprehensive, systematic manner of data analysis and is guided by the following eight steps:

- I intended to first read all the transcripts in order to get a sense of the whole.
- One transcript from each of the data sets (perceived as the most interesting and comprehensive) would then be selected and studied in order to determine the essence and implied meaning thereof.
- The above-mentioned task would be repeated with all the transcripts, after which I planned to identify and cluster topics together.
- The topics would then be abbreviated as codes and the latter would be placed next to the relevant segments of text.
- My plan was to then identify descriptive wording for each topic, after which I intended to categorise and group related topics together.
- A final decision regarding the abbreviations for each category would thereafter be made and the abbreviations would be alphabetised.
- I planned to consequently place data belonging to each category together and perform a preliminary analysis.
- Upon completion of this, my intention was to compile a report, based on above-mentioned analysis.

I furthermore intended to make use of the services of an independent coder. Such a person is a researcher-practitioner who is well-versed in qualitative research, with the purpose of analysing the dataset independently from myself and also according to Tesch's framework, in order to ensure consensus about the identified themes and categories.

2.5.6 Ensuring the trustworthiness of the study and data verification

The importance of data verification in a qualitative research study is emphasised by several scholars (Bless, Higson-Smith & Sithole, 2013:236; Yin, 2011:78). This process concerns itself with checking the accuracy and credibility of the research findings from the perspective of the researcher, the participants of the study, and the reader(s) of the research study (Creswell, 2009:202; Welman et al., 2005:142; Creswell, 2003:196; Krefting, 1991:214-215). It is explained as follows by Morse, Barrett, Mayan, Olson and Spiers (2002:17):

Verification is the process of checking, confirming, making sure, and being certain. In qualitative research, verification refers to the mechanisms used during the process of research to incrementally contribute to the rigor of a study. These mechanisms are woven into every step of the inquiry to construct a solid product.

This latter part is also confirmed in the assertion by Alston and Bowles (2003:48) that data verification has to take place during the processes of data collection and data analysis, as well as during the process of writing the research report.

I proposed to apply Lincoln and Guba's (1985) seminal work and constructs for evaluating qualitative research. These authors suggest that a qualitative study should achieve "trustworthiness" in that the findings should represent as closely as possible the accounts and perspectives of the participants (Lietz & Zayas, 2010:191). According to this model, the following four concepts work together to achieve trustworthiness: credibility, transferability, auditability, and confirmability (Wu et al., 2016:496-497; Lietz & Zayas, 2010:191; Krefting, 1991:215). These concepts are defined further to provide guidelines for evaluation and each of the concepts relate to an aspect/criterion of trustworthiness, namely truth-value, applicability, consistency, and neutrality:

- **Credibility relates to truth-value:** Truth-value refers to whether the researcher has established confidence in the truth of the findings for the subjects, as well as the context in which the study was done (Guba & Lincoln, in Krefting, 1991:215).

It seeks confirmation for the question “How congruent are the findings with reality?” (Merriam, in Shenton, 2004:64). In qualitative research studies, truth-value is usually obtained from the discovery of human experiences as they are lived and perceived by informants (Krefting, 1991:215). The following strategies are proposed in order to establish confidence in the truth of the findings:

- **Interviewing techniques** include listening, questioning, probing, and the use of silence or pausing.
- **Triangulation** relates to obtaining multiple perspectives by using different methods of data collection, as well as different sources (Wu et al., 2016:496; Terre Blanche et al., 2006:287; Shenton, 2004:65-66; Krefting, 1991:219). It was my intention to use triangulation of data sources and data methods. With reference to the first, I planned to collect data from both TSs and SPs. I furthermore planned to use both semi-structured interviews and focus group discussions to collect the data required.
- **Peer examination** is viewed as a profitable strategy for data verification and gauging the trustworthiness of the study and the research findings presented (Krefting, 1991:219). According to Shenton (2004:67), “opportunities for scrutiny of the project by colleagues, peers and academics should be welcomed, as should feedback offered to the researcher at any presentations (e.g. at conferences) that are made over the duration of the project”, as this could result in a refinement of the research methods (Shenton, 2004:67) and increased methodicalness (Botha, 2014:91). I planned to consult my study supervisor throughout the study, as well as fellow colleagues in the field.
- The **authority of the researcher** adds to the trustworthiness of the findings of a research study (Krefting, 1991:217). According to Patton (in Shenton, 2004:68), the credibility of the researcher, with reference to his/her background, qualifications, and research experience, is of particular importance in qualitative research, as the researcher is the main instrument of data collection and analysis. I expected that my experience as a social

worker (I have been practicing social work since 1990), my professional engagement specifically with TSs dealing with UPs and TOPs (I have been working in the field of higher education since 2004), as well extensive experience in qualitative research (dating back to 1993, when I was an undergraduate student, and including the completion of my Master's degree in Social Work and my recent doctorate studies) would demonstrate my ability and credibility in terms of executing this project²⁵.

- **Transferability relates to applicability:** This bears reference to the degree to which the findings of the research study are applicable, fitting, or useful to theory, practice, to other groups or contexts, and future research (Wu et al., 2016:496; Guba & Lincoln, in Lietz & Zayas, 2010:195; Shenton, 2004:69; Krefting, 1991:216). To create a foundation for transferability and allow other researchers to use the findings in comparing it to their own work, the importance of a research report containing an accurate description of the research process is emphasised. I intended to do this by devoting Chapter Three of this thesis to report on how the research methodology was applied and Chapter Four and Five for a presentation of my research findings. In addition, I would make every effort to provide clear arguments for why different choices were made and I planned to provide a thick or detailed description of the research context, as this would facilitate an assessment of how findings may be applicable to other settings (Lietz & Zayas, 2010:196; Shenton, 2004:69-70).
- **Consistency is defined in terms of dependability,** referring to the ability of others to confirm or corroborate the findings and this relates to auditability (Marshall & Rossman, 2016:262). This refers to whether the findings would be consistent if the inquiry were replicated with the same subjects or in a similar context, and is achieved through the strategy of auditability (Lietz & Zayas, 2010:195; Shenton, 2004:72; Guba, in Krefting, 1991:216). The proposed

²⁵ My role in shaping the credibility of the findings of this research study is elaborated upon in Chapter Three (Section 3.5.5).

strategies enabling auditability entail the provision of a dense description of the research methodology, triangulation, peer examination, and the use of an independent coder to independently analyse the data set.

- **Confirmability is the criterion of neutrality.** In this regard, neutrality in qualitative research refers to freedom from bias in the research procedures and results, as well as the degree to which the findings of a study are a function solely of the informants and conditions of the research (in other words, no other biases or motivations) (Lincoln & Guba, 1991:217). This would be achieved through applying reflexivity, with me being aware of my own thoughts, feelings, and ideas, as well as through triangulation of data sources and methods (Krefting, 1991:218) as referred to earlier.

The presentation of the practical activities proposed for this research project in terms of sampling, data collection, data analysis, and ensuring the trustworthiness of the study and data verification is herewith concluded. An overview of the ethical issues proposed for consideration while conducting this research study will now be presented.

2.6 ETHICAL CONSIDERATIONS

In explaining the concept “research ethics”, Schnell and Heinritz, quoted by Flick (2015:32), state:

Research ethics addresses the question of which ethically relevant issues caused by the intervention of researchers can be expected to impact on the people with or about whom they research. It is concerned in addition with the steps taken to protect those who participate in the research, if this is necessary.

Wassenaar (in Terre Blanche et al., 2006:61) holds a similar point of view when stating that the basic purpose of research ethics is to protect the welfare of research participants. He adds that research ethics should be a fundamental concern of all social science researchers in planning, designing, implementing, and reporting

research with human participants. According to Christians (2005:144), ethics can be seen as a set of considerations applied by researchers with regard to what is morally right or wrong. The moral and professional obligation that researchers have with regard to ethics, whether a participant is aware thereof or not, is also emphasised by Neuman (2012:131; 2006:129).

Beauchamp and Childress (in Terre Blanche et al., 2006:67) identify four philosophical principles that could be applied to determine whether research is ethical, namely –

- autonomy and respect for the dignity of persons (this principle finds expression in most requirements for voluntary informed consent by all research participants, as well as the protection of anonymity);
- nonmaleficence (the researcher is required to ensure that no harm or wrongs befall research participants as a result of their participation in the research);
- beneficence (this principle obliges the researcher to consider the potential risks that the research may bring to participants and to attempt to maximise the benefits that the research will afford to the participants); and
- justice (this principle requires that researchers treat participants with fairness and equity during all stages of the research process).

Emanuel, Wendler, Killen and Grady (in Terre Blanche et al., 2006:68) add to these principles by offering a framework based on the following eight practical principles that have specific operational implications and should enhance the ethical standing and scientific value of research:

- Establishing a collaborative partnership (researchers must ensure that the research they are conducting is developed in collaboration with the target population).
- The research endeavour should have social value (the research should address questions that are of value to society).
- The research process should be scientifically sound and rigorous in that the approach, design, and research methods should be familiar within the

parameters of the discipline, and methods used should be justified and rigorously applied to produce valid answers to research questions and research findings.

- The use of acceptable participant recruitment techniques is proposed to select participants who are from populations to whom the research question applies.
- The research should have more benefits than risks for the participants partaking.
- The research endeavour should be approved by an independent ethical review committee and should include peer review and examination.
- Informed consent should be obtained from participants and participation should be voluntarily.
- Ongoing respect for participants and study communities should be upheld.

Against these introductory remarks on research ethics, the ethical principles that I intended to uphold while conducting this research study will now be discussed in more detail.

2.6.1 Obtaining informed consent

Obtaining informed consent implies that people are adequately informed about a proposed research project and that they understand what it means to participate in such a research study, so that they can decide in a conscious way whether or not they want to participate voluntarily (MacQueen, in Guest et al., 2013:325; Leedy & Ormrod, 2005:101). They should also be told that, should they agree to participate, participation would be strictly voluntarily and that they have the right to withdraw from the study at any time. Hepworth et al. (2013:65) emphasise that this information must be conveyed in clear and understandable language.

In adhering to the ethical principle of obtaining informed consent, I envisaged having several informal contact sessions (telephone calls, e-mail correspondence, and meetings) with potential and actual participants with the purpose of (aside from my intention of establishing and maintaining contact and relationships) outlining the

research process, with reference to the purpose and procedures of the research; participants' roles, rights, and responsibilities; the potential risks and benefits of the study; the ethical considerations that I planned to observe during the study; and an explanation of what participation would entail with an emphasis on voluntary participation and the right to withdraw at any time.

Furthermore, as part of the research plan, I intended to provide individuals identified from the population groups of TSs and SPs with written invitations (cf. Annexure B & C) to participate in the research. It was my intention that these invitations would formally address and comprehensively explain the issues mentioned above, but that the invitations would also include a requirement that participants should sign an informed consent form as agreement that they participate out of their free will and based on the fact that they had been comprehensively informed about the research. The plan was that the participants would sign the informed consent agreements during formal appointments, and prior to data being collected, once I was sure that all participants were comprehensively informed about the research, that all questions and uncertainties about the research were answered and clarified, and that participation was completely voluntarily.

2.6.2 Avoidance of harm

It is recommended that the physical and emotional risks involved in a research study should not be more than the risks associated with day-to-day living (Leedy & Ormrod, 2005:101). Researchers are ethically obliged to consider the welfare of participants and protect them from any form of physical or emotional harm. The implication hereof is that researchers have a responsibility to not only identify, remove, or correct any aspects of the research which might harm the participants, but also to balance the risks and benefits by minimising the risks to the participants and maximising the benefits that the researcher might generate for the participants (Terre Blanche et al., 2006:71).

I intended to adhere to this ethical principle by planning to ensure that data collection with the participants would be conducted in comfortable and safe environments, adhering to the basic principles of privacy and confidentiality, so as to not expose these participants (especially the TSs) to additional stress, embarrassment, or loss of self-esteem. The collection of data would be planned at times and locations most convenient to the participants in order to minimise disruption to their daily activities. I planned to formulate the questions proposed for the in-depth, semi-structured, face-to-face interviews in a neutral, non-judgemental manner and I anticipated giving these participants the opportunity to share their feelings about the study. It was envisaged that, should I come to the conclusion that any information shared by a participant left her feeling upset or emotionally perturbed, I would refer such a participant, with her permission, for debriefing or counselling.

2.6.3 Right to privacy, confidentiality of data, and anonymity

Privacy is defined as “that which normally is not intended to others to observe or analyse” (Strydom, in De Vos et al., 2011:59) and it implies that, in research, participants have the right to decide when, where, to whom, and to what extent their beliefs, attitudes, and behaviour should be revealed. In addition, privacy entails the right of participants to withdraw from a research study at any stage, without any penalty or consequence, and to refuse to answer certain questions (Alston & Bowles, 2003:21).

Confidentiality, according to King and Horrocks (2010:117), is commonly viewed as equivalent to privacy. Confidentiality, as stated by the mentioned authors, would mean that what is shared by a participant would remain private and not be repeated. This, in the context of qualitative research, seems impossible as the participants’ accounts are to be shared in substantiation of research findings. What the researcher can endeavour to do is manage information in a confidential manner and keep participants’ identities anonymous (King & Horrocks, 2010:117; Strydom, in De Vos et al., 2005:60) so that they would not be recognised by any person other than the

researcher. This is usually achieved by disguising the identity of a participant by using a code instead of the participant's real name (Babbie, 2014:68; De Vours, 2013:58).

In upholding these ethical principles for my proposed study, I envisaged ensuring that the participants' rights to self-determination regarding what to share and whether to share would be respected in that participants would not be forced or coerced to divulge certain information about themselves. I intended to inform and assure them that they could leave the interviews and focus group discussions at any time and that exercising their right to privacy would not impact on any form of service delivery to them. I furthermore intended to assure them that only I, the transcriber, an independent coder, and my promoter would have access to the digital recordings and transcriptions, but that all identifying particulars of the participants would be omitted and anonymised by way of using pseudonyms and codes. My intention was to do the same with the participating tertiary institutions, namely to also replace the real names of the institutions, and where possible, the areas in which they were, with pseudonyms and codes.

All data, with reference to the recordings of the interviews and the focus group discussions, as well as the hard copies of the transcriptions, would be safely stored in a lockable cabinet, and the electronic versions would be password protected on a computer that only I use and have access to.

A detailed discussion of the application of above-mentioned ethical considerations in this study is presented in Chapter Three.

2.7 CHAPTER SUMMARY

The second chapter of this research report provided an introduction to the proposed research plan for investigating the identified research problem. The research questions to be answered through this endeavour, as well as the goals and objectives to be achieved, were presented.

The research methodology, or in other words the research approach and design(s) adopted for this study, was presented and in this regard I indicated that a qualitative research approach would be followed in respect of this study. The research designs, or strategies of inquiry, inherent to the qualitative research approach that I intended to use were introduced and the motivations for my decisions in this regard indicated. My intention was to employ a collective instrumental case study design, as well as the phenomenological research design, in addition to the explorative, descriptive, and contextual strategies of inquiry. The research methods were introduced with reference to the recruitment of participants by indicating the populations for the study and how participants would be sampled from these. The methods that I intended to use for data collection, analysis, and verification were presented. The ethical principles that I anticipated to uphold in this study were also made known.

In the next chapter of this thesis, a description of how the research plan introduced in this chapter was applied will be provided.

CHAPTER THREE:

DESCRIPTION OF THE APPLICATION OF THE RESEARCH METHODOLOGY UTILISED IN THIS STUDY

3.1 INTRODUCTION

In the previous chapter of this thesis, the research plan for investigating the identified research problem was introduced. This chapter will be devoted to a description of how the research plan was executed during the fieldwork in view of realising the goals formulated for this study.

3.2 MY MOTIVATION FOR DESCRIBING THE APPLICATION OF THE RESEARCH METHODOLOGY APPLIED IN THIS STUDY

When adopting a qualitative research approach for investigating an identified research problem, as in the case of this study, the provision of a detailed account of how the research plan was executed is of paramount importance. Such a description, detailing how the research plan was carried out, with references to the research approach, design, and methods, relates to what Seale (in Carcary, 2009:15) refers to as “reflexive methodological accounting”. Such accounting is vital in order to demonstrate that a research study was carried out with considerable care. McBrien (2008:1287) emphasises that in view of such “accounting... inquirers are responsible for ensuring that the process of research is logical, traceable and clearly documented.”

These mentioned requirements point to the establishment of a trail of evidence or an “audit trail” where researchers, in a chronological and systematic fashion, report on the research methodology utilised, indicating what they did, how they did it, and how they arrived at their interpretations (Bowen, 2009:305). The provision of such a trail of evidence enables a researcher who was not involved in the research study to conduct an inquiry audit with the purpose of examining both the process and product of the

research study (Lincoln & Guba, in Amankwaa, 2016:122) as a tenet for establishing the dependability and confirmability²⁶ of qualitative research findings (Bowen, 2009:307). It compels a qualitative researcher to provide a detailed written account of the research process, highlighting the theoretical, methodological, and analytical choices made and reporting on what occurred throughout the research project along with a demonstration of reflexivity (Lietz & Zayas, 2010:196; Bowen, 2009:307). Against this background, Schwandt (in Bowen, 2009:307) explains the concept “audit trail” as “a systematically maintained documentation system” of all the research-related aspects. This documentation system can be equated to what Carcary (2009:16) labels a “physical audit trail” process documenting the stages of a research study and reflecting the key research methodology decisions.

Thomas and Magilvy (2011:153) provide some of the specifics to be included in the trail of evidence for audit purposes. This should include the following:

- A purpose statement for the study.
- A description on how, why, and from where the participants were selected for the study (in other words the fieldwork related to participant recruitment).
- A description of how the data were collected and the length of the fieldwork engagement (in other words the fieldwork related to data collection).
- An explanation of how the data were reduced or transformed for analysis (data analysis).
- The presentation and interpretation of the research findings.
- A description of the specific techniques employed to determine the credibility of the data (in other words, strategies employed to ensure the trustworthiness of the research findings).

²⁶ Dependability entails the effort to show that the findings are consistent and could be repeated (Amankwaa, 2016:121), whilst confirmability “refers to the ability of others to confirm or corroborate the findings” (Lietz & Zayas, 2010:197).

In addition to the pointers provided by Thomas and Magilvy (2011:153), Shenton (2004:71) accentuates the following aspects to be comprehensively presented in order to enable an inquiry audit:

- The research design, imbedded in a particular research approach/paradigm as adopted for the particular study should be introduced and a description provided on how it was executed.
- The operational detail of data gathering should explain in fine detail what was done in the field.

Against the introductory remarks on why a detailed description of how the research plan was implemented is necessary, and what aspects should be covered in such a description, the remainder of this chapter will be devoted to a description of how the research plan was operationalised. Whilst embarking on this activity, I wish to concede that I will have to cross-reference and refer back to information provided in Chapter Two where I introduced the proposed research plan for this study. This will be done by revisiting and further elaborating on some of the chosen research methodology-related aspects and concepts as discussed in the previous chapter. This way of reporting or type of discussion may be viewed or critiqued by the readers of the report as repetitive, but I deemed it justifiable in view of providing a thick description of the methodology and the phenomenon under scrutiny employed as a provision for promoting the credibility of the study (Shenton, 2004:69).

3.3 THE NATURE OF THE QUALITATIVE RESEARCH APPROACH

The reader was informed earlier in this chapter as well as in Chapter Two of this report about my intention to approach this research project from a **qualitative perspective**. Although the concept “qualitative research” was introduced in Chapter Two (see Section 2.4.1), I wish to provide, by way of recapitulating, the following description of what qualitative research is: qualitative research affords researchers, adopting this approach, an opportunity to examine people’s experiences in detail by using various research methods (such as in-depth-interviews, focus group

discussions, observations, content analysis, visual methods, and life histories/biographies). Qualitative research furthermore allows for the identification of issues from the perspectives of the study's participants in an attempt to try and understand the meanings and interpretations they give to experiences, behaviour, events, or objects (Wu et al., 2016:494; Flick, 2015:24; Wahyuni, 2012:71; Hennink et al., 2011:8-9).

In addition to introducing the concept “qualitative research”, the characteristics underpinning the qualitative research approach were mentioned in the previous chapter by way of introduction and I also provided features and pointers for when this approach would be the best fit for a topic under investigation (see Section 2.4.1). In latching on to this introduction and based on the characteristics of qualitative research, the qualitative nature of this study will now be reflected upon.

Qualitative research is exploratory, exploring identified variables and topics on which little or no previous research has been conducted (Rubin & Babbie, 2013:95; Morrow, 2007:211; Alston & Bowles, 2003:34; Creswell, 2003:154). In adopting this characteristic of qualitative research, I set out to explore the experiences, support, and support needs of TSs who had experienced an UP and/or a TOP. In addition, I explored the perceptions of SPs rendering support services to TSs with UPs and/or TOPs regarding the experiences and support needs of these students. I also went on an explorative journey to gain information about the scopes of the support services rendered by the SPs to TSs presenting with UPs and/or TOPs. The eventual aim with this exploration was to inform the formulation of practice guidelines for psychosocial support directed at SPs offering support services to TSs presenting with UPs and/or TOPs.

Qualitative research is conducted in a natural setting in that researchers as key data collection instruments collect data in the field at the site where participants experience the issue or problem under study (Creswell, 2014:107-108; Yin, 2011:13; Creswell, 2009:175-176). In elaborating on this aspect of the natural setting,

Chesebro and Borisoff (2007:8) aver that the qualitative researcher attempts to make the research experience part of the participants' everyday routine and their environments (cf. Creswell, 2014:185). Participants are not required to attend a laboratory type of setting to participate in the research project, but they are interviewed and/or observed in a safe and comfortable environment known to them (Keyton, in Chesebro & Borisoff, 2007:6). This study was conducted within the context of tertiary/higher education institutions. I was the key instrument in the process of data collection and I collected the data myself through consulting more than one source of data, namely observing behaviour and interviewing participants. The in-depth, semi-structured, face-to-face interviews that were conducted with the TSs took place at their place of study, to be more specific, the tertiary institution(s) where they were registered, in a comfortable and safe environment, namely offices normally utilised for counselling purposes, adhering to principles of privacy and confidentiality. These venues were provided with the assistance of the SPs who acted as gatekeepers in that they assisted with the identification and initial recruitment of the TSs and arranged for me to have access to them. The focus group discussions, and in some cases semi-structured, individual interviews²⁷, that were conducted with the participating SPs, were conducted at their places of employ at the tertiary institutions and in the case of SPs at the participating CPCC, at their head office. The private offices and meeting rooms suggested by the SP-participants for data collection were regarded as safe spaces known to them, making it ideal for the interviews.

Qualitative research requires researchers to be reflexive (Creswell, 2014:186; Birks, in Mills & Birks, 2014:22). For Birks (in Mills & Birks, 2014:22), reflexivity is a process of actively engaged and insightful research work and reflection on how the researcher's involvement and decisions impact on the process and outcome of the research. This author advises that "maintenance of a reflective journal and writing of

²⁷ In some cases, instead of conducting focus group discussions with the participating SPs, I had to resort to conducting semi-structured, individual interviews. This was done where only one or two SPs from a specific setting were available to participate in the study. A detailed discussion of this process is presented later in this chapter (Section 3.5.3).

memos can provide a written record for [such] reflexivity” exercises (Birks, in Mills & Birks, 2014:22). I thus kept a research journal in which I noted research methodology decisions that I took and choices that I made; observations in the data collection dyads with participants; as well as feelings that I had prior to and during the interviews, which I reflected on afterwards. The value of keeping such a research journal is emphasised by Whittaker (2012:4), who states that it promotes reflexivity and could assist the researcher with examining his/her thoughts and decisions made during the research process.

Qualitative research is descriptive, resulting in data that is open-ended, enabling researchers to make inferences about some characteristics or behaviours of the population and the multi-layered complexities of the phenomena that were explored and investigated (Creswell, 2014:154; Mathani 2004:57). According to Rubin and Babbie (2013:51), social work studies often have the purpose of describing. The researcher first observes and explores, and then carefully and deliberately describes. The research objectives formulated for this endeavour included descriptive purposes. The information resulting from exploring the aspects related to the topic under investigation from the experiences and perceptions of the sampled TSs and the SPs allowed for such descriptions.

The qualitative approach furthermore concerns itself with interpretation, which is quintessential when a researcher departs from an interpretivist position. Interpretivism posits that the phenomenon researchers are interested in studying is not straightforwardly perceivable, as it is constructed by each researcher in a different way (Thomas, 2017:110), as well as by the participants who are experiencing or have experienced the phenomenon being explored. Thus, within the qualitative research paradigm, there is not one singular objective truth, but multiple subjective truths that upon discovery have to be interpreted. It therefore challenges the traditional scientific approach of positivism and argues that the methods of the natural sciences cannot be used to study social phenomena (Whittaker, 2012:9).

It is asserted that the interpretation of qualitative data includes identifying patterns and explanations that lead to conclusions (Whittaker, 2012:9; Alston & Bowles, 2003:207). These conclusions can be tested through further data collection, reduction, and interpretation (Yin, 2011:7). In applying this characteristic of qualitative research being interpretive, I ventured out to explore the various aspects related to the topic of investigation from the vantage points of the TS- and SP-participants' experiences. The aim, from the outset of this study, was not the generation of absolute truths, but rather to gain an in-depth understanding of the experiences, support, and support needs of TSs with UPs and/or TOPs, as well as the perceptions of the SPs rendering support services to these students in relation to this phenomenon.

As the intent with qualitative research is not to generalise findings beyond the study's sample, but rather to obtain in-depth context embedded information on a particular phenomenon through the meaning that the sampled participants attach to it, **smaller samples** are advocated for qualitative research **with participants being purposively recruited** (Wu et al., 2016:498; Yilmaz, 2013:313; Morrow, 2007:216). Creswell (2016:7) explains the part on "smaller samples" as follows: "In qualitative research we study a small number of people but go deep to develop the detail they provide to us." In this study, two population groups were identified, namely all TSs enrolled at four of Gauteng's tertiary institutions who have experienced an UP and/or TOP, and all SPs – volunteer counsellors, healthcare professionals, social workers and psychologists – who render support services to students with UPs and/or TOPs at these tertiary institutions in Gauteng. From these populations a total of six TSs and 23 SPs, upon recruitment and screening, met the criteria of inclusion and formed part of the respective sample groups for this study.

As far as the characteristic of qualitative research referring to the **researcher as the key instrument in the process of data collection** (Creswell, 2014:185; Yilmaz, 2013:317) is concerned, I gave execution to this by conducting in-depth, semi-structured, face-to-face interviews with the TSs sampled. In order to obtain the

information required from the SPs, both focus group discussions and semi-structured, individual interviews were conducted. The in-depth, face-to-face interviews with the TSs were fitting, given the sensitive nature of the topic (Dempsey et al., 2016:480).

Qualitative researchers traditionally follow an inductive or bottom-up approach and process when it comes to data analysis (Creswell, 2014:186; Yilmaz, 2013:317) by following coding strategies to allow themes to emerge from the data. Through this exercise, logical principles or explanations are developed from specific observations as the researcher becomes immersed in the detail and specifics of the data in order to determine important themes and the interrelationships (Rubin & Babbie, 2013:369) between them. In this study, through inductive reasoning, I, and an independent coder, analysed the transcripts of the interviews and focus group discussions independently from each other. Similar themes and slightly different sub-themes, categories, and sub-categories on the experiences and needs of the populations were identified and, in a consensus discussion, crystallised and consolidated.

Keeping the nature of the qualitative research approach in mind and given the description of the operationalisation thereof in this study, a discussion of the research design, as highlighted in Chapter Two (Section 2.4.2), will now be presented.

3.4 APPLICATION OF THE RESEARCH DESIGN

While the use of completely open-ended designs in quantitative research would be considered non-theoretical, the concept of an emergent research design is inherent in and a hallmark of most qualitative projects (Bruce, Beuthin, Sheilds, Molzahn & Schick-Makaroff, 2016:2). The idea of an emergent design was presented in the previous chapter where the research plan for the study was introduced (see Section 2.4.2).

In explaining the emergent nature of qualitative research, Brown (in Litchman, 2014:40) writes:

We don't always know until we're well into the project where we are placing our emphasis. Often we change directions and take new tacks in the midst of the work, due to our own realisation about the material, and in part from the ongoing interpretation with people.

For this reason, the “research design” as a plan or strategy of scientific inquiry (Babbie, 2010:89) should not, in the realm of qualitative research, be seen as fixed, but rather as “a rough sketch” that will become more detailed as the study emerges (Frankel & Devers, 2000:253). Keeping this in mind, and in view of the commitment of providing a trail of evidence, the researcher needs to indicate how the proposed research design was applied. Where the researcher had to divert from that which was originally planned or anticipated, such diversion needs to be indicated and explained. Even where difficulties were encountered, an account must be provided of how these were overcome (Busetto, Luijckx, Calciolari, González-Ortiz & Vrijhoef, 2017:2).

As initially planned, I remained with the **collective instrumental case study design** and the **phenomenological research design**, which are both qualitative research designs (Lichtman, 2014:99; Creswell et al., 2007:238, 240). In addition, and as originally intended, I employed an **explorative, descriptive, and contextual strategy of inquiry**.

An elaboration on how the above-mentioned research designs were applied in this study will now be presented.

3.4.1 The collective instrumental case study design

The collective case study design (Thomas, 2016:172; Creswell et al., 2007:236; Stake, 2005:445) was employed instrumentally (Thomas, 2016:121; Snow et al., 2009:234). This research design allowed for engaging with multiple sources comprising both TSs and SPs, within a bounded system, namely the context of higher education, with the purpose of gaining an in-depth understanding of and insight into

the issue of UPs and TOPs amongst TSs. In addition, requesting suggestions from both the TSs and the SPs interviewed also assisted with the formulation of practice guidelines for psychosocial support. Aside from instrumentally facilitating an in-depth understanding of the phenomena and informing practice, the use of multiple cases (data sources) also contributes towards increasing the validity of a study (Crowe, Creswell, Robertson, Huby, Avery & Sheikh, 2011), as research findings deduced from different sources or as a means of triangulation of data sources ensures confirmability and completeness of the findings (McBrien, 2008:1286).

3.4.2 The phenomenological research design

Phenomenology may be the method of choice when a researcher wants to study what an experience means to a particular group of people (Grossoehme, 2014:117). As it was my intention to specifically tap into the TS sample group's lived experiences (Yates & Leggett, 2016:229; Polkinghorne, 2005:238) in relation to their UPs and/or TOPs, and the meaning they ascribed to their experiences, I employed transcendental phenomenology as part of the strategy of inquiry in view of this sample group specifically.

My role in applying this strategy was to extract the essence of the mentioned lived experiences through a reductionist process or bracketing (Creswell, 2016:262-263; Lichtman, 2014:114). The latter implied that I had to suspend my pre-existing interpretations, judgements, knowledge, experiences, and understanding of the phenomenon and instead focus on how the experience is perceived by the participant. I therefore, in operating from a transcendental phenomenological vantage point, continuously engaged in a reflexive self-dialogue, especially while interviewing the TS-participants. I continuously evaluated my biases, experiences, and past knowledge about the research topic (Finlay, 2012:176). In addition, I also engaged in regular conversations with fellow researchers and my supervisor to put in abeyance my presuppositions in attempting to get closer to the participants' experiences (Moustakas, in Creswell & Poth, 2017:78; Finlay, 2012:176; Tufford & Newman,

2012:84; Morrow, 2007:217). I made notes of these conversations and regular reflection on it assisted me to mitigate the potentially harmful effects of preconceptions that could taint the research process (Tufford & Newman, 2012:84). Furthermore, in an attempt to enable participants to express themselves as freely as possible so as to reveal their lived experiences, I formulated the requests and questions directed at them in an open-ended, neutral manner. I made use of probes and applied empathic listening, which enhanced my awareness of the experiences and feelings of the participants (Tufford & Newman, 2012:85). I achieved a deepened, comprehensive understanding of the meanings implied within the participants' articulated experiences through in-depth engagement with the data through the application of the eight steps prescribed by Tesch (in Creswell, 2014:198) to thematically analyse the data. The themes deduced from this exercise were underscored by quotations in order to produce a thick description of the phenomenon and the process guiding the understanding thereof (Moustakas, in Creswell & Poth 2017:78; Yin, 2011:213). The application of this process enabled me to not only unwrap and expose layers of the phenomenon, but also to present the research findings in a rigorous way and pave the way for a dependability audit (Yin, 2011:213).

3.4.3 The explorative, descriptive, and contextual strategy of inquiry

To realise the objectives of exploring and describing the phenomenon under investigation, an explorative, descriptive, and contextual strategy of inquiry was employed, as originally planned. For a description on what the “explorative”, “descriptive”, and “contextual” aspects forming part of the strategies of inquiry entailed, and the motivation for using these stated strategies of inquiry, the reader is advised to revisit Chapter Two (Section 2.4.2.3).

In order to *explore* the “breadth and scope” (Bless et al., 2013:57) of the phenomenon being studied, I conducted in-depth, semi-structured, face-to-face interviews with the participating TSs, as well as focus group discussions and some semi-structured individual interviews with the participating SPs. This enabled me to uncover and

discover knowledge about the experiences, support, and support needs of the TSs, the perceptions of the SPs about the experiences and support needs of said students, as well as the scopes of support services offered by the SPs, which I *described* with the purpose of providing a detailed picture thereof.

Given the fact that qualitative research findings are highly context and case dependent (Yilmaz, 2013:315), the *context* in which the exploration about the issue at hand is done and on which a detailed descriptive account is to be provided needs to be acknowledged (Neuman, 2012:92). For this reason, Creswell and Poth (2017:322) suggest that the case contexts surrounding the issue being studied be delineated. In this regard, these authors make reference to the broad and narrow case contexts. The broad context represents the political, economic, and historical aspects surrounding and shaping the issue being researched. With reference to the topic under investigation, the political, economic, and historical contexts surrounding the issue may be focused on the discourses of female students' opportunities for higher education; the redress of inequalities and women's access to higher education; and women's rights and decision-making power when it comes to their own bodies, and sexual and reproductive health. Included in the mentioned contexts is the phenomenon of UPs and/or TOPs amongst TSs; its impact on students' academic progression and university's throughput rates; and the cost-implications for both the tertiary institutions and the students. The narrow conceptualisation of the case context, on the other hand, signifies the participants' personal, relational, community, and socio-cultural contexts (Creswell & Poth, 2017:322; Hennink et al., 2011:288), as it relates to their UP and/or TOP experience.

The information collected through this context-based exploration and the suggestions gathered from the participants would ultimately inform the formulation of practice guidelines for psychosocial support directed at SPs offering support services to TSs presenting with UPs and/or TOPs.

3.5 APPLICATION OF THE RESEARCH METHODS

The concept “research methods”, as discussed in Chapter Two (see Section 2.5), refers to the tools, techniques, and procedures applied for the purpose of conducting a research project. It relates to the activity of determining the study’s population; the process of sampling and sampling techniques employed to obtain a sample of participants from the population or participant recruitment; how the data is to be collected and analysed; and techniques to be employed for data verification or for establishing the trustworthiness of the research findings (Loh, 2013:5; Wahyuni, 2012:72; Kumar, 2010:7-8; Leedy & Ormrod, 2005:12).

In the ensuing discussion, the research methods, as proposed in Chapter Two, are revisited and elaborated upon, and a description of the application thereof in this endeavour is provided. Any diversion from the original plan, specifically with regard to the research methods, and/or any addition/adoption of other research methods will be clarified and substantiated.

3.5.1 Population, sample, and sampling techniques

As explained in Chapter Two, the concept “population” refers to the total group of people or objects of concern in a research study from which a sample is drawn with the purpose of attaining the necessary information (Punch, 2016:175).

Sampling, commonly referred to as participant recruitment in qualitative research (Hennink et al., 2011:84), involves the selection of participants from the population with the purpose of participating in a research study in order to study the phenomenon under investigation (Neuman, 2012:146; Monette et al., 2011:506).

Given the fact that a study’s population provides pointers on who the participants to be sampled are, I revisited the goals formulated at the outset of the study to recap who the populations, from where I had to sample participants from, were. I also kept

in mind that in qualitative research the participants recruited should be those who are information-rich to provide detailed answers to the research questions, or should even be the ones who have first-hand experience in relation to the issue being explored (Merriam & Tisdell, 2016:96; Wu et al., 2016:498; Reybold et al., 2012:702-703; Hennink et al., 2011:84; Suri, 2011:65). In the application of my research plan, I remained with the geographically demarcated population initially defined for this study (elaborated upon in Section 2.5.1 and 3.3), as budget and time restrictions motivated me to do so.

My decision to remain within the geographical boundaries originally set for the study was motivated by budget and time restrictions. As stated in the research plan, I reside in Gauteng and to delimit the geographical boundaries to focus on only northern and southern regions of Gauteng seemed a logistically and financially executable option.

My realisation that it would be impossible to study every case that was of interest to me, more so because I included two populations in my investigation, resulted in me having to choose samples from the populations of interest (Neuman, 2012:146; Hennink et al., 2011:84; Monette et al., 2011:506). I therefore applied purposive sampling as the strategy for participant recruitment and remained with the criteria of inclusion initially formulated to recruit information-rich participants (Grossoehme, 2014:112; Suri, 2011:69). The reader is advised to revisit Section 2.5.1 for the criteria of inclusion used to recruit participants from the identified populations.

Adhering to the mentioned inclusion criteria enabled me to recruit six TS-participants and 23 SP-participants from the four participating tertiary institutions and the CPCC. The application of the process applied to identify and involve the above-mentioned participants is presented in the next section of this chapter.

With regard to the aspect of the sample size in qualitative research and the sample size for this study, I took the view of Hennink et al. (2011:88) into consideration. The authors claim that sampling in qualitative research continues until themes emerging

from data collected are fully developed, or where data has reached a point of saturation. This is normally signified during the data collection stage where themes in the data are recurring and/or no new information, insights, and perspectives emerge (Suri, 2011:72). Yin (2011:89) adds to this by stating that "...there is no formula for defining the desired number of units for each broader or narrower unit of data collection in a qualitative study", but that data saturation determines the sample size (cf. Hennink et al., 2011:88; Koerber & McMichael, 2008:467). I consequently remained with my initial intention (described in Section 2.5.2) of not setting a fixed sample size at the outset of my study, but rather being guided by the principle of data saturation. To determine whether data saturation was realised in this study, I followed the advice of Litchman (2014:251), who recommends that a researcher should immediately upon collection of the data, continue with the process of analysing it. Therefore, after each individual interview, I listened to the digital recording thereof, after which the recording was transcribed. While reading through the transcript, I asked myself if the information gathered from the specific interview that had just been conducted differed in any way from the previous one(s). Any differences were noted for future reference and consideration, which enabled me to become aware of recurring information, themes, and patterns, leading me to the conclusion that I had reached the point of data saturation. Next, I consulted with my supervisor and the independent coder to confirm that data saturation was indeed achieved, after which the process of data collection was concluded.

Having completed the process of identifying the populations for my study, as well as the sampling methods, I proceeded with the process of participant recruitment. The manner in which this process was applied is described in the next section.

3.5.2 Participant recruitment

Negotiating access to research settings and participants requires a researcher to have a clear understanding of who the stakeholders, role players, and gatekeepers central to a research study are (Loh, 2013:2; Devers & Frankel, 2000:3). Establishing

contact with potential participants and maintaining good relationships with the ones who have been recruited and found to be eligible for participation is of key importance when one needs to collect data that has to be rich, detailed, and extensive (Yilmaz, 2013:317). Gaining entry into and cooperation from fieldwork settings and potential participants is described by Feldman et al. (2003:x-xi) as “relational, continuous and dynamic”. They emphasise that the self-presentation of the researcher (also referred to as the identity of the researcher), and in the context of the researcher being a scholar/student, influences access. According to them, researchers can draw from identities, such as their “profession, geographic affiliation, political ideology, hobby or interest, gender, race and age” to create connections with other people (Feldman et al., 2003:x-xi).

In qualitative research, the researcher is seen as the research instrument (Nichols, 2009:591; Devers & Frankel, 2000:3). Feldman et al. (2003:xi) agree with this sentiment and they concur that gaining access, as a relational process, requires that the researcher must:

- have good relationship-building skills;
- be able to be flexible and persistent “without being annoying”; and
- be able to “recognize luck and accept opportunities when they are offered” (Feldman et al., 2003:xi).

As mentioned earlier in this research report, I identified two populations for my study. The populations focused on in the geographically demarcated area resulted in me needing to gain access to multiple sites, namely to four tertiary institutions and a CPCC in Gauteng.

In order to gain entry to and cooperation from the fieldwork settings, the stakeholders, and gatekeepers, obtain permission to conduct research in these settings, and be allowed access to the participants intended for inclusion in this study, I applied the procedure proposed in Chapter Two (see Section 2.5.2) and as schematically depicted in Figure 3.1.

I also utilised some of the practical and theoretical hints and guidelines suggested by Feldman et al. (2003:6) and Oates and Riaz (2016:54) for qualitative researchers in pursuit of the challenging process of gaining access to different/multiple field settings, namely to request the SPs to act as gatekeepers but also participate in the research study, and offering to share the research findings with the participants.

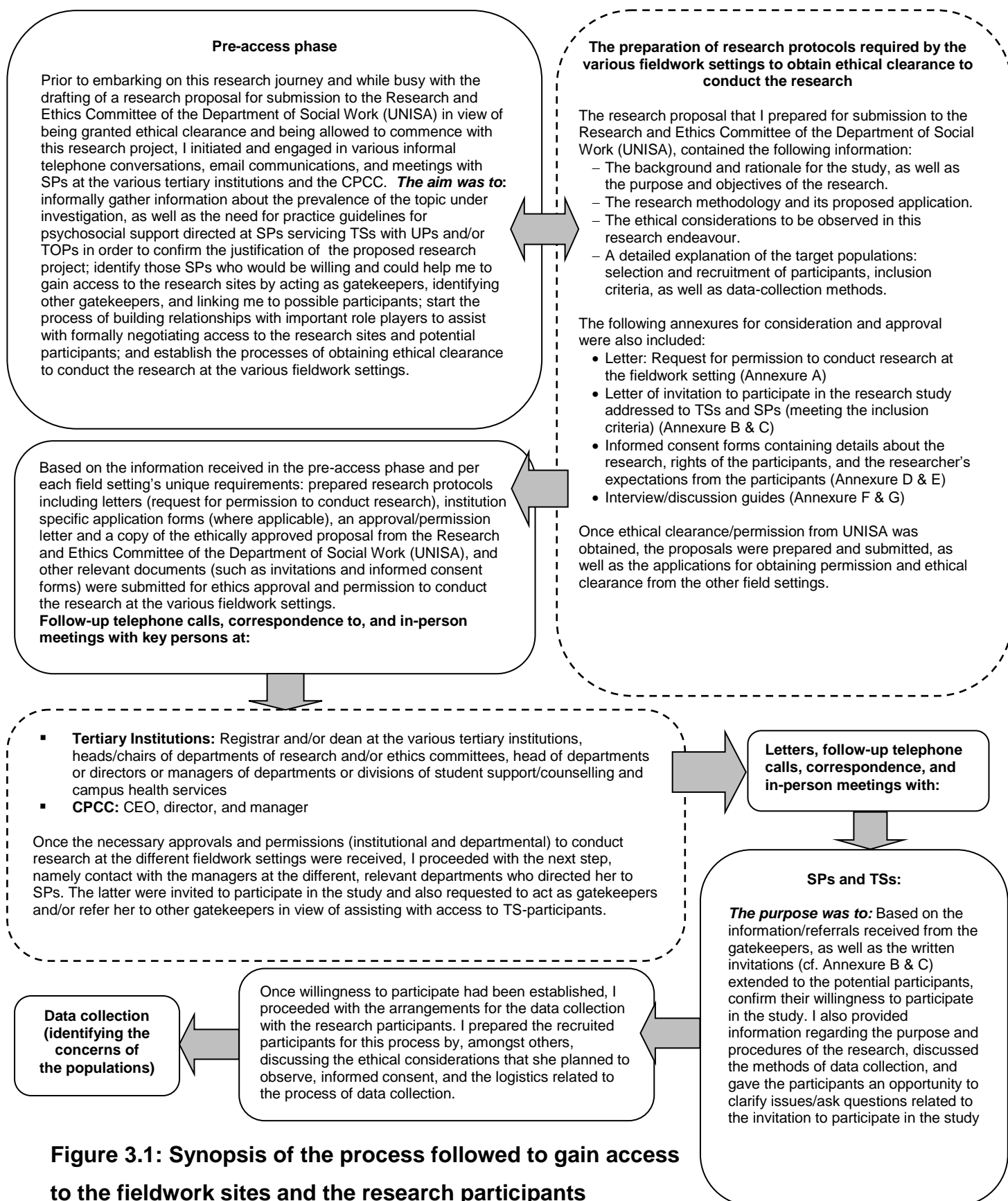


Figure 3.1: Synopsis of the process followed to gain access to the fieldwork sites and the research participants

A detailed description of how I applied the activity of participant recruitment, as depicted in the synopsis presented in Figure 3.1 above, will now be presented.

3.5.2.1 The pre-access phase in view of negotiating access to the fieldwork settings and potential participants

With negotiating access to a fieldwork setting and potential participants, securing the consent of people in authority within and over such a setting is a prerequisite for most social research endeavours (Pole & Hillyard, 2016:27). This activity, as mentioned earlier, is regarded as a relational and continuous process (Pole & Hillyard, 2016:27; Feldman et al., 2003:vii). Identifying role players who can assist with negotiating access to a specific setting and potential participants is not only beneficial, but of paramount importance. Mastering the “art of self-presentation” or, putting it differently, “to present a version of self in such a way as to appeal to those you wish to work with and thus gain cooperation from” (Pole & Hillyard, 2016:43), together with the researcher’s intentions, as well as the purpose of the research, has a major influence on whether a researcher will be granted entry into a specific setting. Miller and Glassner (2004:127-128) confirm this train of thought by adding that participants’ responses to a researcher and/or research project is very often determined by “who the researcher is”.

The process of establishing relationships in view of gaining access to the fieldwork settings and potential participants, according to Feldman et al. (2003:xii, 23) and Johl and Renganathan (2010:42-43), entails the following:

- Finding the people with whom the researcher wishes to have a relationship with (the stakeholders, gatekeepers, and participants within the populations identified for the study).
- Seeking permission and gaining approval for the relationship.
- Making initial contact (by means of letters or face-to-face contact) to introduce the research and the researcher: this involves the application of the preparation

that the researcher applied in the first stage to secure initial access to the populations that he/she wishes to study.

- Establishing the type of relationship (in other words, establishing a rapport with the participants) necessary for access to the information that is required by the researcher.
- Exit (closure or ending the relationship).

My employment and standing as a social worker providing counselling services to students at an institution of higher education since March of 2004, as well as my involvement in various research projects being conducted at this tertiary institution, worked to my benefit in terms of negotiating access to the fieldwork settings and ultimately to potential participants. It enabled me to gain an understanding of and insight into the basic institutional processes, procedures, and protocol that had to be adhered to when engaging in a research endeavour at an institution of higher education. Frequent interaction with my peers offering counselling services at other tertiary institutions in Gauteng enabled me to establish an extensive network of contacts and resources. I normally engaged with these peers at conferences, meetings, institutional forums, training seminars, and workshops, as well as those from the CPCC, various state departments, and NGOs. My standing, professionally, inside my institution and at the other tertiary institutions, as well as in the social work field, lubricated the process of gaining access to and cooperation from the various fieldwork settings and potential participants targeted for my research.

As proposed in Chapter Two and illuminated in Figure 3.1 above, prior to embarking on this research journey I initiated contact with and engaged with several of the mentioned SP peers and colleagues inside my institution, at other tertiary institutions, and also at social service organisations. This contact was by way of informal telephone conversations, email communication, and meetings.

The purpose of these informal discussions was in the first place to enquire about the prevalence and/or extent of the problem of UPs and TOPs amongst TSs, and whether

there was a need for practice guidelines for psychosocial support directed at SPs servicing TSs with UPs and TOPs. The feedback that I received in this regard enabled me to establish the following:

- The phenomenon of UPs and TOPs was perceived as a serious problem affecting the psychosocial function and wellbeing, as well as the academic performance and study progression of TSs with grave financial implications for the tertiary institutions in view of throughput targets not being realised.
- Current practice guidelines to address this phenomenon amongst TSs were perceived as insufficient, pointing to a need for specific practice guidelines to provide psychosocial support to students presenting with UPs and/or TOPs.

The SPs thus confirmed the need for research in this regard and also expressed their interest to participate in the proposed research project.

Secondly, the aim was to identify role players who could assist me to gain access to the various fieldwork settings by assisting with the identification of SPs who I could approach to act as gatekeepers or assist with identifying other gatekeepers, and/or who would be willing to participate in the study (forming part of the SP-participant group should they meet the inclusion criteria for participation).

The third aim was to enquire about the logistics and start the process of building relationships in view of formally negotiating access to the research settings and potential participants, while the last aim was to establish the processes of obtaining ethical clearance to conduct the research at the different field settings. I regarded these endeavours as the “pre-access phase”.

The preparatory work of initial engagements with peers is regarded by Feldman et al. (2003:23) as important “time and energy savers”. Gathering important information about a research setting in terms of staff, policies, programmes, and service users and the protocol on applying for permission to conduct research at the setting is strongly advised (Creswell, 2016:109; Bless et al., 2013:69), even more so where

access to multiple sites is required (Feldman et al., 2003:23). Several other authors add in this regard that key informants can explain local ways to researchers and introduce them to gatekeepers who control access to the setting (Oates & Riaz, 2016:54; Desai & Potter, 2006:81-82). Forming collaborative relationships with the representatives of a setting by involving them in identifying problems, planning projects, and implementing interventions not only facilitates access to the setting, but it also enables researchers to conduct their work in a setting where they have the necessary support and cooperation.

The activities applied in the pre-access phase enabled me to make contact with several SPs who indicated their willingness to act as gatekeepers and advise me about the processes of applying for ethical clearance at their respective settings. They furthermore referred me to other possible gatekeepers and participants and/or even agreed to, as SPs, participate in the study. Following this informal engagement with my peers, and after the Research and Ethics Committee of the Department of Social Work (UNISA) approved the research proposal, granting me permission to proceed with my fieldwork, I commenced with the next step, namely gaining entry to and cooperation from the different fieldwork settings.

3.5.2.2 Negotiating entry to and cooperation from the different fieldwork settings

This step centred on the process of gaining access to the study areas, specifically obtaining ethical clearance and permission to conduct research at the following fieldwork settings:

- Four tertiary institutions in Gauteng.
- A specific CPCC (well-known for the support that they render to, amongst others, TSs presenting with UPs and/or TOPs from various higher education institutions in Pretoria, Tshwane).

Receiving ethical clearance from the Department of Social Work at UNISA to proceed with the research (please see Annexure H: Unisa Ethical Clearance Certificate-

Reference number: 41751671_13/04/10_01)) did not automatic imply ethical clearance from the other universities identified as potential fieldwork sites. I had to apply afresh at each of the universities for permission to conduct research at their institutions and for obtaining ethical clearance. In view of this, I executed the following activities required by the formal hierarchy (established in the pre-access phase) through which to negotiate access:

- I drafted an official letter (see Annexure A) in which I supplied the following information: my background, the rationale for and goal of the proposed research, as well as the logistics regarding the research (the type of access that I required). Information regarding the target populations, methods of data-collection and the management thereof, and the ethical issues to be observed were also included. The aim of this letter was to request permission to conduct research at the various tertiary institutions and was submitted to the registrars and/or deans; the heads/chairs of research and/or ethics committees, the directors/managers or HODs (from departments of student support/counselling and campus health services) at the various tertiary institutions.
- I familiarised myself with the protocol, channels to follow, and prescribed institution-specific application forms to be completed in view of requesting permission to conduct the research and for obtaining ethical approval from the respective tertiary institutions. The required application forms were meticulously completed and submitted to the relevant person(s) and/or committees. All application forms were accompanied by my approved research proposal, as well as the ethical clearance certificate issued by the Ethics and Research Committee of the Department of Social Work at UNISA. Additional applicable documents (namely the invitations to potential participants in view of considering their possible participation in the research project, a sample of the informed consent forms, and interview/discussion guides – see Annexure B, C, D, E, F & G) were also submitted for consideration and approval.

I was cognisant of the fact that gaining permission from the different tertiary university fieldwork sites and the institutional review processes (with the latter having the advantage of protecting both the researcher and the participants, who may be vulnerable) could be lengthy and drawn-out processes. I was also mindful of the fact that this could be further exacerbated by organisational issues, such as communication problems, work overload at certain times of the year, and difficulty in achieving coordination among members of the review boards/ethics committees (Feldman et al., 2003:16). For this reason, I submitted my applications simultaneously to the different institutions. This provided enough time for reviewing the applications and obtaining permission, as well as allowing for clarification and/or changes requested by the respective committees should the need therefore arise. Obtaining permission from the various tertiary institutions targeted as fieldwork sites for this research project took nine months²⁸.

Gaining access to the CPCC was less time-consuming and challenging. Over the past 14 years in my role as social worker and student counsellor at a tertiary institution, I managed to establish and maintain a good working relationship with the management and staff of the CPCC. Several community projects and outreaches were facilitated between the tertiary institution where I am employed and the CPCC (these projects include annual awareness campaigns and training workshops aimed at, amongst others, addressing sexual health issues and the prevention of UPs and TOPs amongst TSs). An effective referral system between the two organisations has been established with staff from the tertiary institution referring students to the CPCC and vice versa. The relationship between myself and the CPCC staff can be described as one that is characterised by mutual respect, professional support, and effective cooperation. These factors led to access to the CPCC and the research participants being facilitated without any difficulty. The managers of the centre were

²⁸ The Ethical Clearance Certificates for the participating tertiary institutions (Tertiary Institution A, B, C and D) are not included in this report in an attempt to protect their identity and maintain the principles of confidentiality and anonymity. The documents are stored in a safe place and are available for perusal and upon request.

extremely positive and supportive with regard to their involvement and participation in this research study.

I formally applied for permission to conduct my research at the CPCC by means of a letter (see Annexure A in this regard) that was submitted to the CEO of the organisation. I was invited to attend a meeting with the managers of the centre, during which I explained the following: the purpose and procedures of the research, the target populations, inclusion criteria, and ethical principles to be adhered to. I received permission²⁹ to conduct the research at the CCPC after a managerial review of my application, my approved research proposal, and the ethical clearance that was received from UNISA.

Obtaining permission to conduct my research at the different fieldwork settings (in other words, gaining access to and cooperation from the research sites) enabled me to proceed with the activity of recruiting potential participants (SPs and TSs) for participation in the study.

3.5.2.3 Negotiating access to the participants (namely SPs and TSs)

Once the necessary ethics approval and permission were received from the highest level institutionally at the tertiary institutions and from management level at the CPCC to conduct the research, I proceeded to get permission from management at a lower level in the hierarchy. I initiated contact with the directors/managers or HODs (such as the departments of student support/counselling and campus health services) at the various tertiary institutions, as well as the manager at the CPCC with the request, amongst others, for them to act as gatekeepers or to refer me to individuals who could act as gatekeepers to regulate or provide access to the proposed populations (namely SPs and TSs).

²⁹ Written permission to conduct the research was received from the participating CPCC. This document is not included in this report in an attempt to protect the identity of the CPCC and maintain the principles of confidentiality and anonymity. The document is stored in a safe place and is available for perusal and upon request.

With reference to gatekeepers, Feldman et al. (2003:31) assert that “access via a gatekeeper often makes research easier”. Gatekeepers are essential as they can vouch for the legitimacy and trustworthiness of the researcher and assist with the recruitment and retention of participants (Burckett & Morris, 2015:110). Cassel (in Clark, 2010:487) notes that gatekeepers oversee physical access by permitting or refusing the researcher access to the fieldwork setting and contact with the participants, and also assist with the identification of possible participants (Creswell, 2009:90,178; Leedy & Ormrod, 2005:137). The participants, on the other hand, are in charge of social access in view of having the power to refuse or consent to participate in the research (Cassel, in Clark 2010:487).

A letter (see Annexure A) explaining the purpose of the research and requesting permission to conduct research at the departments where the SPs were employed (namely student counselling units and the campus health services/campus clinics) was sent to their directors/HODs. The institution-specific ethical clearance obtained accompanied these letters. Once the buy-in/support for the research project from the managers was received, I approached them with a request to arrange and establish contact with the SPs.

My pre-access work prior to embarking on this research journey (alluded to earlier in the discussion) facilitated a relatively smooth process in terms of getting the mentioned buy-in/support from the directors/HODs from the relevant institutions and departments. They were willing to introduce the research project to the SPs and invite them to participate in focus group discussions and/or act as gatekeepers in identifying and referring TSs for possible participation in the study.

Meetings, during which I introduced myself and explained the purpose and procedures of the research, were held with the SPs at all the fieldwork settings. My expectations of the SPs with regard to their participation were clarified during these meetings. Subsequently, they were invited, in writing (see Annexure C), to participate

in a focus group discussion where their perceptions about the experiences and needs of TSs presenting with UPs and/or TOPs, and the scopes of support services offered to such students, would be explored. Other research-related details were also shared and discussed, such as the location and duration of the focus group discussions, assurance regarding anonymity and confidentiality, as well as the assurance that only myself, my promoter, the transcriber, and the independent coder would have access to the digitally recorded interviews and transcripts of the focus group discussions (in which their identities would be anonymised). Following this discussion, I made arrangements with the SPs to contact them (telephonically or via email) to establish and/or confirm their willingness to participate in the research study. Once their willingness to participate was confirmed, appointments were made for the data collection.

My request to the SPs to act as gatekeepers (elaborated upon above) also entailed requesting that they identify TSs with UPs and/or TOPs, who had made an appointment with a SP for counselling or support in this regard, or whom they knew of. I requested that they enquire from such students about their possible participation in my research project after being informed about the study's goal and what their participation would entail. Should the TSs indicate an interest, the gatekeeper SPs were requested to hand them a written invitation (see Annexure B) requesting that they consider participating in the research study. The identifying particulars and contact details of the ones who had indicated an interest and willingness to participate in this research project would then be passed on to me via the gatekeepers.

I then made telephonic contact with the students who indicated their interest in and willingness to participate in the research study, following the written invitation given to them by the relevant SPs, and based on the declaration of interest expressed on the form attached to the written invitation (cf. Annexure B) requesting them to sign the declaration, confirming that they have read the invitation and that they were willing to participate in the research. The following transpired during this telephonic contact: I thanked the students for indicating their interest in and willingness to participate and

discussed the content of the written invitation (cf. Annexure B) that was given to them by the SPs, explaining the purpose and procedures of the research; their role, rights, and responsibilities; the potential risks and benefits involved in participating; as well as the ethical considerations that I planned to observe during the study. I elaborated on the method of data collection and the logistics surrounding this process, after which they were given an opportunity to ask any questions related to the research study and/or their participation. Once their willingness to participate was confirmed, appointments were made for the data collection.

The discussion on the application of the process of negotiating access to and cooperation from the multiple sites, as well as how the participants were recruited is herewith concluded. The focus of the discussion will now shift to the process of data collection and how it was applied.

3.5.3 Pilot testing and data collection

Prior to engaging the participants recruited in data collection to explore the topic being investigated and as proposed in Chapter Two, the data collection methods and questions in the interview guides were **pilot tested** and I also gauged my competency and skill level in terms of conducting qualitative data collection interviews. Although this concept and the purpose thereof was elaborated upon in detail earlier in this research report (see Section 2.5.4), the meaning thereof will be briefly recapitulated. A pilot study refers to a smaller version of the anticipated research study in order to answer a methodological question and to guide the development of the research plan. It provides the researcher with an opportunity to test and refine one or more aspects of the final study, in other words adjust the research method and identify weaknesses or shortcomings in the data collection process (Punch, 2016:51; Yin, 2011:37). The importance of this exercise is emphasised by several scholars (Wahyuni, 2012:74; Hennink et al., 2011:120; Desai & Potter, 2006:169), as it helps to assess whether the questions in the interview

guides are pitched at the participants' level of comprehension and fit the purpose and context of the study.

In following the advice of Maxwell (2013:101), who states that "if at all possible, you should pilot-test your interview guide with people as much like your planned interviewees as possible", I applied the same criteria for inclusion as set out for the participants for the main study (described in Section 2.5.1 and depicted in Table 2.2) for the recruitment of individuals to participate in the pilot test. The same data collection methods as proposed for the main study were also used, namely:

- An in-depth, semi-structured, face-to-face interview with a TS presenting with an UP and/or TOP.
- An invitation was extended to the student to, subsequent to the interview, write a letter to share any additional information regarding her experience and/or needs related to her UP and/or TOP.
- A focus group discussion was facilitated with a group of SPs that render support services to TSs with UPs and/or TOPs.

With the permission of the individuals who participated in the pilot test, the informed consent forms were signed, confidentiality and anonymity were discussed, and the interviews were recorded, transcribed, and coded. This pilot study, conducted with one TS who had an UP and chose single parenting, and one focus group discussion conducted for the purpose of pilot testing, provided me with the following insights:

- Sharing her story and the experiences around the topic of an UP brought up intense emotions for the student. This sensitised me to the fact that due to the sensitive nature of the topic, ample time needs to be made available for debriefing after the interview.
- With regard to conducting the pilot focus group discussion, I aware of the importance of effective time management (some of the participants elaborated extensively on some of the questions and even deviated from the topic under discussion). This once again sensitised me to allow for extra time, but it also emphasised the importance of the utilisation of my reflective and summarising

skills in order to respond in a non-judgemental manner, with empathy, while also directing the focus of the conversation back to the question under discussion.

Upon completion of the pilot study, I continued with the process of involving the recruited participants and identifying their concerns through utilising the methods of data collection decided upon at the outset of the study as per the research plan (see Section 2.3), and which will be presented below.

- a) In-depth, semi-structured, face-to-face interviews and letter writing as methods of data collection to identify the concerns of the TS sample group

The SPs at the different field settings played a major role in assisting me to identify potential TS-participants. As mentioned earlier in this report, as well as per the original research plan, they were requested as part of their gatekeeping role to assist with the identification and referral of TSs who met the stated inclusion criteria for possible participation in the research study. The SPs who provide support to TSs presenting with UPs and/or TOPs, or who knew of such students, were requested to introduce the study to the students. A letter (see Annexure B) informing them about the study and inviting them to consider participating had to be passed on to such students. Students who, based on the information provided to them, indicated a willingness to participate were asked to sign a declaration of interest form to participate in this study, which was returned to me. It also contained their contact details and granted me permission to contact them. In Table 3.1, an exposition is provided of referrals received from the SPs.

Table 3.1: Synopsis of the referrals of potential TSs from the respective SPs

Fieldwork setting	Referrals received	Participants who consented to participate and after being found eligible for participation were recruited to form part of the sample of TSs
Tertiary Institution A	Two referrals/declarations of interest were received from two of the SPs employed at this institution.	One of the students who initially indicated her interest withdrew when she was contacted with the purpose of officially recruiting her for the study (she did not provide a reason for her withdrawal, but

		just stated that she no longer wished to be part of the research process). The other student consented to participate and was duly and comprehensively informed and prepared for data collection
Tertiary Institution B	No referrals from the SPs employed at this institution were received	
Tertiary Institution C	No referrals from the SPs employed at this institution were received	
Tertiary Institution D	Three referrals/declarations of interest were received from two SPs employed at this institution.	The potential participants were contacted and they confirmed their willingness to participate. They were duly and comprehensively informed and prepared for data collection
The CPCC	Two referrals/declarations of interest were received from two SPs at the CPCC: – 1x TS registered at Tertiary Institution C – 1x TS registered at Tertiary Institution D	These potential participants were contacted to confirm their willingness to participate. They agreed to participate and were duly and comprehensively informed and prepared for data collection

Upon receipt of the forms from the SPs who acted as gatekeepers and referral sources, signed by the students declaring their interest in participating in the study and granting me permission to contact them, I contacted the potential participants telephonically. I introduced myself, stated the reason for my call, and enquired if they were still interested to participate in the study. For those who expressed their continued interest, I once again went through the information in the documentation given to them by the SPs (see Annexure B). Before ending the telephone conversation, I arranged to meet with them on a specific date, at a time and place convenient to them, in order for them to sign the informed consent form and to engage with them in an in-depth interview on the topic being investigated. The assistance of the SPs again proved to be invaluable in this regard, as they allowed me to make use of their facilities (a private office was provided) for data collection purposes.

Following the above-mentioned telephonic contact with each of the participants to confirm the date, time, and venue for the data collection, a semi-structured, in-depth one-on-one interview was conducted with each of them. At this occasion the following transpired:

- The purpose of the research study, as well as the questions that would be asked, were once again briefly discussed and explained and questions posed by the participants were answered.
- Voluntary participation and the aspects of confidentiality and anonymity were discussed and informed consent forms were signed by the participants.
- After obtaining the information from the respective participants in order to compile a biographical profile, the topic-related requests and questions in the interview guide were entertained. The participants were invited to speak freely, without interruption and, where necessary, I probed for further clarification and elaboration.
- Each participant was observed carefully to assess whether the information that was shared left her emotionally upset or perturbed, in which case the participant was referred (with her permission) for debriefing or counselling. Arrangements were made in advance with the relevant SPs, should the need for debriefing or counselling arise or become apparent.
- Upon conclusion of the interview, an invitation to write a letter was extended to each participant. The purpose of the letter was explained, namely to add, share, or reflect on any additional information regarding her experience that she either did not think of or feel comfortable sharing during the interview, but that she deemed necessary or relevant. An envelope, addressed to me, with writing paper and a postage stamp, was given to each participant with the request to post the letter within one month of the interview. I emphasised that the writing of such a letter was strictly voluntary and that the purpose was to share, anonymously, any additional information regarding each participant's experience and/or needs related to her UP and/or TOP.
- The process of involving and identifying the concerns of this participant group was concluded with a follow-up telephone call a day or two after the interview, during which each participant was thanked for her time and valuable contribution. I referred to the potential benefits that might come of the study and an invitation to contact me was extended, should feedback regarding the outcome of the research study be required.

In Table 3.2, a summary is provided depicting the date, time, and duration of the in-depth interviews that were conducted with the TS-participants. An indication of the referral of any of the participants for debriefing or follow-up counselling, based on my observational notes and monitoring of the participants, is given, as well as an indication of whether any letters, as per my invitation to the participants, were received.

Table 3.2: Tabulated overview of the in-depth, semi-structured, face-to-face interviews that were conducted with the TS-participants

Fieldwork setting (interview venue)	Date, time and duration of interview	Observational notes and indication of referral of participant for debriefing/follow-up counselling	Letter received from participant
Tertiary Institution A	➤ Participant F: 16/05/2011 @ 11:00 Duration: 80 minutes	<i>Participant initially appeared nervous specifically regarding the audio recording of the interview. After she was assured regarding the anonymity and confidentiality of the interview, she answered the questions freely and comfortably.</i> No need for debriefing/referral.	No
Tertiary Institution B	No referrals received		N/A
Tertiary Institution C	No referrals received		N/A
Tertiary Institution D	➤ Participant A: 13/08/2010 @ 13:30 Duration: 90 minutes	<i>Very little signs of emotional upset; participant shared freely and comfortably.</i> No need for debriefing/referral.	No
	➤ Participant B: 31/08/2010 @ 12:00 Duration: 70 minutes	<i>Very few signs of emotional upset; participant shared freely and comfortably.</i> No need for debriefing/referral.	No
	➤ Participant C: 31/08/2010 @ 14:30 Duration: 70 minutes	<i>Participant appeared nervous and became very emotional during the interview. She also struggled to understand some of the questions and had difficulty in expressing herself, specifically regarding her emotions.</i> She did receive support and counselling from the SP who referred her for participation and she agreed to be referred back to said counsellor for debriefing/follow-up counselling.	No
	➤ Participant E: 22/10/2010 @ 09:00 Duration: 70 minutes	<i>Participant initially appeared nervous, specifically regarding the audio recording of the interview. After assurances regarding the anonymity and confidentiality of the interview she answered the questions freely, but became very emotional. She confirmed that she was still receiving counselling.</i> Participant was referred back to her counsellor, who was also the SP who referred her for participation.	No
CPCC	➤ Participant D: 15/09/2010 @ 11:00 Duration: 60 minutes	<i>Participant shared freely and comfortably. She did however express a lot of anger and resentment and confirmed that she was still receiving counselling.</i> Participant was referred back to her counsellor, who was also the SP who referred her for participation.	No

Conducting the in-depth, face-to-face interviews with the TS-participants provided me with an “inside” view of their experiences and support needs related to their UPs and/or TOPs (Greeff, in De Vos et al., 2011:351-352). The semi-structured nature of the requests and the open-ended questions also allowed for me to follow-up on what the participants said to keep them focused on the topic and to probe for further clarification when necessary (Terre Blanche et al., 2006:299).

- b) Focus group discussions as method of data collection to identify the concerns of the SP sample group.

I originally planned to only use focus group discussions as method of data collection to explore the aspects related to the topic under investigation from the vantage point of the SPs. However, in some cases, I had to resort to conducting a semi-structured, individual interview instead of a focus group discussion, where only one or two SPs from a specific setting consented to participate in the research study, or if they requested to be interviewed individually. This addition of the semi-structured, face-to-face interviews to the focus group discussions with SPs was permissible given the fact that the idea of an emergent design in qualitative research is advocated (Bruce et al., 2016:2; Frankel & Devers, 2000:253).

In Table 3.3 (on the next page) an exposition is provided of the SPs per tertiary institution and from the CPCC who participated in a focus group discussion or who were interviewed individually.

Table 3.3: An institution-wise synopsis of the SPs who participated in a focus group discussion or who were interviewed individually

Fieldwork setting	Service providers
Tertiary Institution A	Six SPs from this institution consented to participate in the research study. Of this number, five formed part of a focus group discussion while one SP, a healthcare professional, requested to be interviewed individually. The focus group comprised of one clinical psychologist, one counselling psychologist, and three educational psychologists.
Tertiary Institution B	Only one participant, an educational psychologist, came forward to participate and she was subsequently individually interviewed.
Tertiary Institution C	Only two participants were recruited from this institution and they were interviewed individually. The one was a social worker and the other a counselling psychologist.
Tertiary Institution D	From this institution, four participants were recruited. Of this number, three SPs, namely two counselling psychologists and a social worker, agreed to engage in a focus group discussion, whilst the other participant, a healthcare professional, preferred to be interviewed individually.
The CPCC	Ten SPs from the CPCC agreed to participate in this study. They were divided in two groups of five participants each. Although they were all volunteer counsellors at the CPCC, the biographical information about their highest qualification and occupation that was collected indicated that the one group was made up of a qualified social worker, a qualified teacher, a qualified photographer, a pastoral counsellor and a housewife, whilst the other group comprised of an information technology specialist, a qualified teacher, a housewife, a qualified accountant, and a pastoral counsellor.

As stated earlier in this chapter, after being granted permission to conduct the research at the different fieldwork settings, I requested the HODs/managers to arrange and establish contact with the SPs. Meetings were held with the SPs at the different settings to, amongst others and as elaborated upon extensively earlier in this chapter, request their participation and supply them with detailed information about the research project. This, together with the initial introduction of the project to the SPs by their HODs/managers (also elaborated upon earlier in this chapter) and the written invitation given to them (cf. Annexure C), ensured that the prospective participants were well informed about the study and duly prepared for the process of data collection.

Once the willingness of the SPs to participate was established, I engaged in the process of making arrangements for the data collection, namely the practical arrangements (date, time, and venue) and confirming participant attendance, after

which the focus groups and/or semi-structured individual interviews were conducted³⁰. The following transpired during these occasions:

- The purpose of the research study and the questions that would be directed to them were once again briefly discussed and questions posed by the participants were answered.
- Voluntary participation and the aspects of confidentiality and anonymity were also discussed again and informed consent forms were signed by the participants.
- The SPs were assured that neither they nor their service delivery were being evaluated, but that their specialist knowledge, skills, and input were requested in order to assist me with the development of guidelines for support, from a social work perspective, that would assist SPs in their service delivery to TSs presenting with UPs and/or TOPs.
- After obtaining the information from the participants in order to compile a biographical profile, the topic-related questions in the discussion/interview guide were entertained. I ensured that the questions for the focus groups and semi-structured individual interviews were directed to the participants in a neutral and non-judgemental manner.
- The participants were invited to discuss and freely share their perceptions of TSs' experiences and support needs related to UPs and/or TOPs, as well as their experiences and needs in relation to the provision of support services to said students. Where necessary, I probed for further clarification and elaboration.
- Arrangements for debriefing were made, but referrals in this regard proved to be unnecessary.
- The process of identifying the concerns of this participant group was concluded with a follow-up email and/or telephone call a day or two after the focus group discussion or semi-structured individual interview, during which the participants were thanked for their time and valuable contributions.

³⁰ I ensured that the concerns of the SP participant group were identified in an environment perceived by them as familiar, safe, and comfortable, namely private offices and/or counselling or meeting rooms utilised by the HODs/managers at the different field settings. The schedules of the SPs were also taken into consideration, thus data was collected on dates and at times that were convenient for them, in order to minimise disruption to their daily activities.

Four focus group discussions, consisting of a total of 18 SP-participants, and five semi-structured, individual interviews were conducted. In the table below, a summary is provided depicting the date, time, and duration of the focus group discussions and semi-structured, individual interviews that were conducted with the SP-participants.

Table 3.4: Tabulated overview of the focus group discussions and semi-structured, individual interviews that were conducted with the SP-participants

Fieldwork setting (interview venue)	Date, time, and duration of focus group/interview	Observational notes
Tertiary Institution A	➤ Focus Group Discussion (FG#4)³¹: 01/06/2011 @ 10:00 <i>Duration: 80 minutes</i>	Five participants who all shared freely and comfortably. No need for debriefing/referral of any of the participants.
	➤ Interview (RI#1): 16/05/2011 @ 13:00 <i>Duration: 48 minutes</i>	Participant was late for interview (had to attend to an urgent matter) and initially seemed flustered and unsure regarding some of the questions. She however relaxed after a few minutes and shared freely and comfortably. No need for debriefing/referral.
Tertiary Institution B	➤ Interview (RI#2): 07/06/2011 @ 13:00 <i>Duration: 45 minutes</i>	Participant shared freely and comfortably. No need for debriefing/referral.
Tertiary Institution C	➤ Interview (RI#4): 17/08/2011 @ 10:00 <i>Duration: 60 minutes</i>	The interview was interrupted twice because of urgent phone calls that the participant had to attend to. She however shared freely and comfortably. No need for debriefing/referral.
	➤ Interview (RI#5): 17/08/2011 @ 13:00 <i>Duration: 55 minutes</i>	Participant shared freely and comfortably. No need for debriefing/referral.
Tertiary Institution D	➤ Focus Group Discussion (FG#3): 27/08/2010 @ 13:30 <i>Duration: 68 minutes</i>	Three participants who all shared freely and comfortably. No need for debriefing/referral of any of the participants.
	➤ Interview (RI#3): 10/06/2011 @ 10:00 <i>Duration: 50 minutes</i>	Participant shared freely and comfortably. No need for debriefing/referral.
CPCC	➤ Focus Group Discussion (FG#1): 12/08/2010 @ 10:30 <i>Duration: 94 minutes</i>	Five SPs participated in this discussion. Two participants asked to be excused briefly during the discussion, but returned after a few minutes. Another participant, an Afrikaans-speaking lady, expressed a slight discomfort with answering in English, but was given the opportunity to answer some of the questions in her mother tongue. Her answers

³¹ The focus group discussions/interviews were numbered, for example FG#4 refers to Focus Group number four, and RI#1 refers to research interview number one. This was done to ensure confidentiality of data. A discussion of the application of this ethical principle is presented later in this chapter (see Section 3.6.3).

		and comments were translated to English. On a few occasions I had to refocus the participants to return to the questions posed in order to keep them focused. I also had to ask them to rephrase a few times, as some of them tended to divert from the initial discussion. All of the participants shared freely and comfortably, however. No need for debriefing/referral of any of the participants.
	➤ Focus Group Discussion (FG#2): 20/08/2010 @ 8:30 <i>Duration: 98 minutes</i>	Five participants who all shared freely and comfortably. No need for debriefing/referral of any of the participants.

As planned, all the interviews and focus group discussions were digitally recorded with the permission of the participants. This was complemented by field notes, reflected upon in the table above, to capture those aspects not picked up by the digital recordings. Furthermore, the interviewing skills referred to in the research plan were employed in order to identify the concerns of the sampled populations.

Completion of the process of data collection enabled me to proceed with the analysis of the data that was collected.

3.5.4 Analysing the data

Data analysis, as introduced in Chapter Two (Section 2.5.5), is described as a process during which the collected data is analysed with the purpose of discovering the meaning of the data that was collected (Fox & Bayat, 2007:106). This is confirmed by several authors who describe qualitative data analysis as a process that draws inferences from a detailed analysis of data that were collected through qualitative data collection methods, as well as a process that involves the analysis of the content, the discovery of regularities, and the understanding of the meaning of the data (Grey, 2014:607; Desai & Potter, 2006:117; Babbie & Mouton, 2007:490).

For Leedy and Ormrod (2005:150-151), data analysis and interpretation are usually closely interwoven and “both are often enmeshed with data collection as well”. In qualitative research, data collection, data analysis, interpretation of the

data, and report writing is seen as an interrelated process where the mentioned steps can take place simultaneously (Creswell, 2014:148; Neuman, 2012:18).

All the digital recordings of the interviews and the focus group discussions with the sampled TSs and SPs were professionally transcribed in an attempt to save time. As the person transcribing the interviews and focus group discussions was not from the field of social work, I went through all the transcripts myself to ensure that I remained in touch with the data and also to ensure that the information was captured correctly (Schurink, Fouché & De Vos, 2011:408).

In order to ensure systematic and comprehensive data analysis, I applied Tesch's descriptive steps for analysing qualitative generated data (Tesch, 1990 in Creswell 2014:198; Tesch, 1990:135), as per the original research plan, with both sets of data that were collected (the data collected from the TSs, as well as the SPs). The framework for data analysis for qualitative research prescribed by Tesch involves eight steps that were applied as follows in this study:

- **Step 1:** I read through all the transcripts of the digital recordings in order to get a sense of the whole. Ideas that came to mind during this process were noted.
- **Step 2:** One transcript from each of the interest groups perceived as particularly interesting and interspersed with rich data descriptions was then chosen and closely scrutinised. I selected the transcript of the second focus group³² that was conducted with the SPs and the transcript of the third in-depth, one-on-one interview³³ that was conducted with a TS for this purpose. While reading these transcripts, I made notes of the underlying meaning as well as the topics and themes that I identified.

³² This focus group discussion was conducted with five volunteer counsellors/SPs from the participating CPCC. Please revisit Table 3.3 and 3.4 above for an overview of the participants' qualifications and occupations, as well as a summary depicting the logistics and observational notes related to the discussion.

³³ This interview was conducted with TS C, a registered student at Tertiary Institution D. A SP employed at Tertiary Institution D referred her for participation in this research study. Please revisit Table 3.1 and 3.2 above for a synopsis of the referrals of TSs, as well as a summary depicting the logistics and observational notes related to the interview.

- **Step 3:** I repeated the second step with all the transcripts. Once I was sure that all the topics were identified, I clustered and labelled them according to their similarities and characteristics. The following are examples of topics that initially emerged from each of the data sets during this process: *“Tertiary students’ feelings and emotional reactions experienced on confirmation of the suspicion of the UP”* and *“Service providers’ perceptions on the experiences and support needs of tertiary students presenting with UPs and/or TOPs”*.
- **Step 4:** Appropriate abbreviations were assigned to each of the identified topics (for example, *“Tertiary students’ feelings and emotional reactions experienced on confirmation of the suspicion of the UP”* was abbreviated to *“ferupts”* and the abbreviation for *“Service providers’ perceptions on the experiences and support needs of tertiary students presenting with UPs and/or TOPs”* was *“PERCEPSPEXPSN”*.

I then reverted to studying the transcripts again and placed the fitting abbreviations next to the appropriate segments of data.

- **Step 5:** During this step, I identified descriptive wording for each topic and turned them into themes. Aside from a few minor changes, most of the wording of the topics was kept as is and adopted as themes. I then proceeded to group related themes together in order to reduce the number of themes. I, without the assistance of the independent coder, identified four themes related to TSs’ experiences, support, and support needs in relation to their UPs and/or TOPs, and their suggestions for practice guidelines for psychosocial support to TSs presenting with an UP and/or TOP. With reference to SPs’ perceptions of TSs’ experiences and support needs related to UPs and/or TOPs, the scopes of support services offered to TSs with UPs and/or TOP, as well as their suggestions for informing practice guidelines for psychosocial support to said students, five themes corresponding to the themes developed from the interviews with the TSs and one unique theme were identified.

- **Step 6:** A final decision was made regarding the abbreviation for each theme and these abbreviations were alphabetised in order to streamline the recoding process of the data should the need for that arise.
- **Step 7:** Data in all of the transcripts belonging to each of the identified/appropriate themes were assembled together. A preliminary analysis was conducted during which I integrated themes in order to provide for a more comprehensive data set.
- **Step 8:** As recommended by Tesch (in Creswell, 2014:198), the recoding process was repeated just to make sure that all the data material had been appropriately placed under the correct themes and that no useful data were thrown away. This recoding exercise enabled me to include what I had regarded as useless data material in some of the categories.

The themes that I identified were confirmed by the independent coder, who analysed the dataset independently from me. During a consensus discussion, facilitated by my supervisor, the independent coder and I discussed, compared, and consolidated the themes, which in some instances branched into sub-themes and categories. The latter are portrayed in the chapters where the research findings are presented.

An exposition of how the data was verified and how the trustworthiness of the study and the research findings were ensured will be presented next.

3.5.5 Verifying the data and techniques for ensuring the trustworthiness of the study and the research findings

The trustworthiness of qualitative research findings is often questioned and met with scepticism, especially by positivist researchers who elevate validity, reliability, and generalisability to the status of a “scientific holy trinity” (Anney, 2014:275; Shenton, 2004:63), whilst these aspects are rather insignificant to qualitative researchers. For qualitative researchers who set their study in an interpretivist paradigm and do not subscribe to the mentioned scientific holy trinity, the focus is

rather on credibility, transferability, dependability, and confirmability for establishing the trustworthiness of their research findings (Anney, 2014:276; Bowen, 2009:306; Shenton, 2004:64; Guba, in Krefting 1991:214). The importance of presenting a true reflection of the people being studied is therefore emphasised (Yin 2011:19; Denzin & Lincoln, 2005:201). Ensuring the accurate representation of qualitative research findings can be obtained by means of **data verification** (Yin, 2011:20; Welman et al., 2005:142). The establishment of the trustworthiness of a study in order to validate the findings and subsequent conclusions is essential. Guba's model (in Krefting, 1991:214-222) was of particular relevance in this regard, as the trustworthiness of the qualitative data obtained in this study was tested against Guba's criteria of credibility, transferability, dependability, and conformability. I will now proceed with a presentation of how the aspects ensuring the trustworthiness of this research endeavour, namely the truth value, applicability, consistency, and neutrality, were applied and achieved. This discussion will be concluded with a tabulated summary thereof.

As originally planned (see Section 2.5.6), confidence in the **truth value** of the findings of this study was established through the application of **credibility**. Credibility strategies or techniques to establish trustworthiness that were applied in this regard were as follows:

- **Triangulation:**

McBrien (2008:1288) explains triangulation "as the combination of two or more theories, data sources, methods or investigators in one study of a... phenomenon... Triangulation increases the accuracy of qualitative research findings in that the data from different sources can confirm the truth" (see Anney, 2014:277). Three types of triangulation were applied, namely:

- Triangulation of data sources: data was collected from various data sources, namely SPs (social workers, psychologists, healthcare professionals, and volunteer counsellors) from different institutions (four tertiary institutions as well as a CPCC) rendering support services to TSs presenting with UPs and/or TOPs. Data was also collected from said TSs.

- Triangulation of data collection methods: data was collected by means of focus group discussions and/or semi-structured, individual interviews with the SPs and by means of in-depth, semi-structured, face-to-face interviews with the TSs. Discussion/interview guides were utilised to structure the focus group discussions and the interviews. Furthermore, a digital voice recorder was used to capture the verbal responses of the participants, but additional data (such as non-verbal communication, etc.) were captured by means of field notes.
 - Investigator triangulation: multiple researchers, namely I, as the principal researcher of this study, the independent coder, and the study's supervisor, were involved in the analysis of the data.
- **Interviewing techniques:**
- The following interview techniques were utilised and applied during the semi-structured, in-depth, one-on-one interviews with the TSs, as well as the focus group discussions and/or semi-structured individual interviews with the SPs: clarification, summarising, focusing, probing, encouragement, and minimal verbal responses. I was careful not to pose several questions at once and verified unclear responses (for example, "I'm sorry, could you please repeat what you just said? I could not quite hear you."). I asked open-ended questions (for example, "Would you explain...?"), as well as follow-up questions, and I made use of probes (direct probes such as "Can you tell me more?", and indirect probes, for example neutral verbal expressions such as "uh-huh" and "I see", as well as non-verbal expressions such as nodding in acknowledgement). Trust and rapport were established with the participants by means of initial contact and/or meetings during which I was able to create interviewer-participant dynamics that were positive and relaxed. The application of these interviewing skills enabled me to fully explore the research question.
- **Peer examination:**
- As explained earlier in this research report (see Section 2.5.6), peer examination involves the discussion of the research process and research findings with fellow researchers and/or colleagues who have experience in

and a good understanding of qualitative research (Lietz & Zayas, 2010:196; Shenton, 2004:67; Krefting, 1991:219). The independent coder and my supervisor, with whom I consulted regularly throughout the research process, were well versed in qualitative methodology. I am also a member of the Departmental Research Forum at my place of employment, which enabled me to attend various presentations and training workshops pertaining to qualitative research (such as Proposal Writing, Qualitative Data Analysis, Presenting Qualitative Data, Writing for Publication, etc.). It furthermore enabled me to liaise with and seek expert advice and guidance from colleagues known for their experience in the field of qualitative research. This enhanced the credibility of this research study.

- **Authority of the researcher:**

I have been practicing social work since 1990, during which time I gained extensive experience in various fields, ranging from substance abuse to being actively involved in addressing the problem of UPs and TOPs amongst TSs, over the past 14 years. I am involved in continued professional development and have received national and international accreditation for completing numerous specialised training courses³⁴. I completed my Master's degree in Clinical Social Work in 1995 and have since then been involved in project development, implementation, and evaluation, aside from applying all the relevant social work methods in daily practice. I have supervised various research projects, presented research papers at local and international conferences, and am currently also involved in other research projects at my place of employment (a tertiary institution, where I have been employed as a social worker since 2004). I am registered with the relevant professional council (the SACSSP³⁵) and am bound by a strict code of ethical conduct. I am thoroughly trained and experienced in the study fields covered by this research project and therefore adequately qualified to undertake this post-graduate research study.

³⁴ These programmes include specialised training (for example, trauma counselling, hypnotherapy, and relationship counselling, to name but a few). The knowledge and skills obtained are relevant and appropriate with regard to the social work service that I render and are utilised on a daily basis.

³⁵ Registration as a social worker with the SACSSP is compulsory in terms of the Social Service Professions Act 110 of 1978 (South Africa, 1978), as amended, and commits social workers to adhere to the Code of Ethics and the Rules for Social Workers made under the Act.

The **applicability** of this study was, as planned, established through **transferability**. Strategies and techniques that may be employed in this regard include a thick description of the research methodology and explanations on how the sample was selected (Wu et al., 2016:496; Anney, 2014:278; Yin, 2011:20; McBrien, 2008:5).

I applied the purposive sampling technique with clear parameters on how participants were selected for inclusion in this study. I made use of gatekeepers (namely SPs rendering support services to TSs with UPs and/or TOPs) who regulated access to the TSs to assist me with recruiting participants from this population group. Transferability is furthermore enhanced through the application of a contextual, explorative, and descriptive research design, whereby a dense description regarding the participants and the findings is provided. The demographic data of the two participant groups, as well as the data that were collected, are discussed and presented in Chapters Four and Five. A thorough description of the application of the methodology, research design, and the methods of data collection and data analysis is provided in this chapter.

The **consistency** of this study was defined in terms of **dependability**. Dependability strategies or techniques that were applied (and elaborated upon above) in this regard were as follows: triangulation of data sources; data collection methods and investigator triangulation; peer examination; and a dense description of the research methodology. I furthermore utilised the code-recode procedure in that I recoded the same data after two weeks of gestation. This was done to compare the results and to check for consistency (Anney, 2014:278; Krefting, 1991:221). The dataset was also analysed independently by an independent coder in order to establish consistency.

Neutrality was obtained through ensuring **conformability**. Strategies that were applied (and elaborated upon above) to enhance the neutrality of the findings of this study include triangulation of data sources, interviewing skills, peer examination, and the authority of the researcher. The applicability of the study and the expert advice and guidance of my supervisor, the independent coder, and my colleagues furthermore enhanced the neutrality of this research study.

The discussion above is summarised in Table 3.5.

Table 3.5: Criteria and strategies employed in order to enhance the trustworthiness of the research findings of this study

CRITERIA	OBJECTIVE FOR TRUSTWORTHINESS	STRATEGY
<i>Credibility</i>	Truth value	<ul style="list-style-type: none"> • Triangulation • Interviewing techniques • Peer examination • Authority of the researcher
<i>Transferability</i>	Applicability	<ul style="list-style-type: none"> • Purposive sampling technique • Dense description of the research methodology
<i>Dependability</i>	Consistency	<ul style="list-style-type: none"> • Triangulation • Peer examination • Dense description of the research methodology • Code-recode procedure
<i>Conformability</i>	Neutrality	<ul style="list-style-type: none"> • Triangulation • Interviewing techniques • Peer examination • Authority of the researcher • Applicability of the study

The presentation of the research methods as applied in this research study is herewith concluded. A description of how the ethical principles that were considered for this endeavour were applied will now be given.

3.6 APPLICATION OF THE ETHICAL CONSIDERATIONS

Ethical issues are concerned with whether the researcher's behaviour conforms to an approved set of principles that regulate behaviour. Ethics in research prevents abuse and misconduct and it assists researchers to act with responsibility. Rubin and Babbie (2013:88) emphasise that the main purpose of ethics is the prevention of harm to research participants.

Alston and Bowles (2003:21) identify the following criteria pertaining to ethical practice in research, specifically with regard to the researcher's relationship with the research participants and they recommend that these be kept in mind when considering the ethical issues of importance. These criteria are self-determination; not doing harm; doing good; and the purposeful and positive contribution to knowledge. The mentioned authors suggest that the researcher ask the following questions in this regard, specifically when conducting qualitative research, as

researchers may face several ethical dilemmas related to data collection and analysis, as well as the dissemination of findings:

- Do participants have an understanding of the potential risks and advantages associated with participation in the research study?
- Did the participants give informed consent?
- What arrangements are in place to ensure confidentiality and privacy?
- Did the researcher make provision for debriefing during the data collection process?

In latching on to above-mentioned, I viewed Yin's (2011:41) use of the term "research integrity" as particularly significant, as it implies that the researcher's "words can be trusted as truthful positions and statements". Research integrity is proven when a researcher explains the point of view represented and communicates possible reservations and uncertainties related to the research study. This can be obtained by disclosing as much as possible about the methodological conditions of the study, as well as the researcher's interests and personal profile. Research integrity can also be maintained by obtaining the necessary approval from the institutional review board(s) and by conducting an honest informed consent dialogue with participants (Maree, 2016:44; Yin, 2011:41). As elaborated upon earlier in this chapter (see Section 3.5.2.1 and 3.5.2.2), I obtained ethical clearance for the study from the Research and Ethics Committee of the Department of Social Work (UNISA), where I am a registered doctorate student. I also obtained permission and ethical clearance for conducting the study at the different fieldwork settings (the activities applied in this regard were elaborated upon in Section 3.5.2.2). I undertook to comply with the ethical principles originally adopted and proposed.

Taking the above-mentioned into consideration, I deemed the following ethical considerations as relevant to the nature and topic of this research study and I applied them accordingly:

- Informed consent
- Avoidance of harm
- Right to privacy and confidentiality of data

3.6.1 Obtaining informed consent

In this study, the following was applied in terms of obtaining informed consent: the individuals identified from the population groups of TSs presenting with UPs and/or TOPs, as well as the SPs rendering support services to said students, received written invitations to participate in the research study (cf. Annexure B and C). These invitations addressed and explained the following:

- The nature and purpose of the study.
- The criteria for inclusion.
- A description of what participation would involve in terms of activities and the duration thereof.
- The method of data collection, namely in-depth, semi-structured, face-to-face interviews, focus group discussions, and personal documents (letters).
- Practical arrangements regarding the data collection (date, venue, and duration).
- Permission to record the interviews was to be obtained.
- A statement indicating that participation was voluntary and could be terminated at any time.
- Any potential risk and/or discomfort that participants could encounter as a result of participating in the study.
- A guarantee that all responses would remain confidential and anonymous.
- My name and information about how I, as the principal researcher, could be contacted.
- Contact details of other individuals that the participants could contact, should they have questions or concerns about the study.
- An offer to provide detailed information about the study upon its completion.

Participants willing to participate in the study were furthermore requested to sign an informed consent form (cf. Annexure D and E). Aside from providing potential participants with written invitations and prior to requesting that they sign informed consent forms, I addressed, amongst others, the logistics related to the study, as well as the participants' roles and rights. This was done during face-to-face contact and/or telephone contact with the potential participants, as elaborated upon earlier

in this chapter. This was an additional measure that I took to ensure that all participants were comprehensively informed and that their participation was completely voluntarily.

3.6.2 Avoidance of harm

The avoidance of harm, as an ethical obligation, is emphasised by Posel and Ross (2014:35), who explain that a researcher should not only attempt to avoid any form of harm to participants, but should also be able to respond to instances where it occurs. In considering this principle, I also took note of Litchman's (2014:57) suggestion to avoid doing anything that might harm a participant and I consequently applied all the strategies proposed in Chapter Two (Section 2.6.2) in order to ensure that I protected the participants in this study from any form of physical or emotional harm.

In my exploration of TSs' experiences and support needs related to their UPs and/or TOPs, I applied the above-mentioned strategies in the following way to adhere to this ethical issue:

- The SPs rendering support services to the mentioned students were co-opted as "gatekeepers".
- In order to not expose the participants to additional stress, embarrassment, or loss of self-esteem, I ensured that the data collection was conducted in a comfortable and safe environment (namely private offices or counselling rooms, made available by the SPs), where the principles of privacy and confidentiality could be adhered to.
- I furthermore ensured that the data collection took place at times and locations that were convenient for the participants. This was done in order to minimise disruption to their daily activities.
- The requests and questions for the in-depth, semi-structured, face-to-face interviews (cf. Annexure F) were formulated in a neutral and non-judgemental manner.
- Participants were given the opportunity to discuss their feelings about the study. If I came to the conclusion that the information that was shared by a

participant in this regard left her emotionally upset or perturbed, I could refer the participant, with her permission, for debriefing or counselling. Arrangements were made with the relevant SPs in this regard.

During data collection with the SP-participants, either through the focus group discussions or the semi-structured, individual interviews, I ensured that the data collection was conducted at times and venues that were convenient for them. The questions (cf. Annexure G) used to collect the required data from them were formulated in a neutral and non-judgemental way. The SPs were assured that neither they nor their service delivery were being evaluated, but that their specialist knowledge, skills, and input were required in order to assist me with the formulation of guidelines for psychosocial support that would assist SPs in their service delivery to TSs presenting with UPs and/or TOPs. They were also given the opportunity to share their feelings immediately after the focus groups and, if needed, be referred to their supervisors for debriefing.

3.6.3 Right to privacy, confidentiality of data, and anonymity

In this study, the participants' right to self-determination regarding what to share and whether to share was respected in that participants were not forced or coerced to divulge certain information about themselves. They could leave the interviews and focus group discussions at any time, and they (the TS-participants) could decide whether or not they wanted to accept the invitation to submit a personal document (letter) pertaining to their experience. Assurance was given that exercising their right to privacy would not impact on any form of service delivery to any of the participants.

The participants were furthermore assured that only the transcriber and I would have access to the digital recordings. In addition, the independent coder and my supervisor would have access to the transcripts of the digital recordings, but I promised to remove identifying particulars to ensure anonymity. The data collected would be stored in a safe place, a locked cabinet at my home, only accessible to me, and all the electronic versions of the transcripts would be password protected on a computer that only I have access to. All identifying information of the

participants in relation to the content of the research study was thus kept confidential and anonymised, specifically with regard to personal particulars. Codes were used when the recorded interviews were transcribed.

The Research and Ethics Committee of one of the participating tertiary institutions requested that this specific institution not be identified. In order to honour this request and to protect/disguise the identity of all four participating tertiary institutions, I renamed them and they were referred to only as Tertiary Institution A, B, C and D in the research report. The name of the participating CPCC, as discussed earlier in this research report, was also withheld with the purpose of establishing and maintaining anonymity and the centre was referred to only as 'the CPCC'.

I used abbreviations A – F to refer to the participating TSs (in other words, they were referred to as Participant A – F). With regard to the data that was collected from the SPs, I used the codes FG#1 – 4 and/or RI#1 – 5 for the focus group discussions and interviews that were conducted. The participating SPs were each given a code (for example, SW-1 for the social worker from participating Tertiary Institution C; Ed-Psych-1 for the educational psychologist from participating Tertiary Institution A; and VC-6 for one of the volunteer counsellors from the participating CPCC).

Hepworth et al. (2013:67) emphasise that all registered social workers are bound by a code of ethics, which respects and ensures the right to privacy and confidentiality when working with people. I am registered with the SACSSP as prescribed by the Social Service Professions Act 110 of 1978 (South Africa, 1978), as amended, and committed to adhering to the Professional Conduct and Ethics code for Social Workers³⁶.

The description of the application of the research methodology utilised in this study is herewith concluded.

³⁶ As prescribed by the SACSSP (<https://www.sacssp.co.za/Conduct>).

3.7 CHAPTER SUMMARY

This chapter started with the presentation of the motivation behind the manner in which I chose to describe the application of the qualitative research process in this research study, namely the utilisation of the qualitative research methodology to provide a decision trail (also referred to as a thick description of the methodology applied) in order to enable a dependability audit to be conducted in the future, should it be deemed necessary. This was followed by a discussion of how I applied the characteristics inherent to the qualitative research approach adopted for this study. Thereafter I elaborated on how the collective instrumental case study and phenomenological research designs were applied, as well as the explorative, descriptive, and contextual research designs. A discussion of the implementation of the research methods was presented in terms of how the research participants were identified and recruited from the different fieldwork settings and how they were prepared for the process of data collection. A detailed elaboration of the methods applied for the collection of the data was presented and a description of the application of Tesch's eight steps for qualitative data analysis (in Creswell, 2014:198) was provided.

The trustworthiness of the study and the trustworthiness of the research findings obtained as a result of this study were ensured by employing Guba's criteria of credibility, transferability, dependability, and conformability (Guba's model, in Krefting, 1991:214-222) developed for this purpose.

The chapter was concluded with a presentation of the procedures that were applied to ensure adherence to the ethical considerations that were relevant to the nature and topic of this study, namely informed consent, avoidance of harm, and the right to privacy, confidentiality of data, and anonymity.

In the next section of this research report, I will report on the findings of the research. The findings relating to the experiences, support, and support needs of TSs presenting with UPs and/or TOPs, as well as their suggestions to inform practice guidelines for psychosocial support will be presented in Chapter Four. The findings relating to the perceptions of SPs regarding the experiences and

support needs of TSs presenting with UPs and/or TOPs, the scope of support services offered by them to this client system group, as well as their suggestions for informing practice guidelines for psychosocial support to said students, will be presented in Chapter Five. The presentation of the findings will be according to themes, sub-themes, and categories that emerged from the data analysis process.

CHAPTER FOUR:

RESEARCH FINDINGS – THE EXPERIENCES, SUPPORT, AND SUPPORT NEEDS OF TSs IN RELATION TO THEIR UPs AND/OR TOPs, AS WELL AS THEIR SUGGESTIONS TO INFORM PRACTICE GUIDELINES FOR PSYCHOSOCIAL SUPPORT

4.1 INTRODUCTION

The previous chapter of this thesis was devoted to a description on how the research plan formulated for the study was applied during the fieldwork. In this chapter, I will present the research findings that emerged from the processes of data collection, data analysis, and the consensus discussion, facilitated by my supervisor, that took place between the independent coder, who independently analysed the transcriptions from the recordings of the data collection, and myself. The findings relate to the experiences, support, and support needs of TSs in relation to their UPs and/or TOPs, as well as their suggestions, for informing practice guidelines for psychosocial support to TSs presenting with an UP and/or TOP.

Prior to presenting the findings, the TS-participants' demographic details will be provided together with a tabulated overview of the themes, sub-themes, and categories that were consolidated during the consensus discussion mentioned above.

In following the advice by Yilmaz (2013:315) that qualitative research reports must provide the reader with sufficient quotations from participants, the themes, sub-themes, and categories will be substantiated with direct quotations from the participants. In addition, the thematic presentation and the supporting storylines quoted from the transcribed interviews will be compared and contrasted with literature and other research findings related to the topic as a means of literature control. The research findings will also be contextualised within the theoretical framework adopted for the study. The purpose of these measures is to enhance

the trustworthiness of the study and the credibility of its findings (Creswell, 2014:202; Streubert-Speziale & Carpenter, 2007:26; Fouché & Delport, in De Vos, Strydom, Fouché & Delport, 2002:269).

As mentioned in Chapter Two and elaborated upon in Chapter Three, I came to the conclusion that the phenomenon being studied in this research project is of a sensitive nature (Ritchie, Lewis, McNaughton Nichols & Ormston, 2014:43; Christians, in Denzin & Lincoln, 2005:145; Ritchie & Lewis, 2003:32-33). Therefore, in order to ensure anonymity and confidentiality, as well as protect the identity of the TS-participants, the participating tertiary institutions, and the participating CPCC, I made use of codes and abbreviations to identify the respective participants (Babbie, 2014:68; De Vos, 2013:58-59; King & Horrocks, 2010:117). The participating TSs were referred to as Participant A, B, C, D, E, and F and the participating tertiary institutions were referred to as Tertiary Institution A, B, C, and D (see Section 3.6.3). The name of the crisis pregnancy care centre was withheld and it was referred to only as the CPCC.

4.2 THE DEMOGRAPHIC DETAILS OF THE TSs WHO PARTICIPATED IN THIS STUDY

Research findings are generated through face-to-face interactions with participants recruited for a study who come from a particular geographical, social, and cultural context. The biographical particulars of such participants, without revealing their identities, and the mentioned aspects related to the context must be introduced to provide a foundation on which to situate the research findings (Creswell, 2016:110; Hennink et al., 2011:288). It was therefore important for me to present the biographical particulars of the TS-participants, as the research findings reported in this chapter relate to them. For the purpose of presenting a biographical profile on the participants, I gathered information focusing on: their ages; academic qualifications enrolled for; the academic year of study that they were in when they participated in the study, as well as the academic year of study when the UP and/or TOP occurred; their place of residence whilst studying; their province/area of origin and hometown; and their ethnicity and language distribution. The mentioned aspects will now be introduced.

4.2.1 The Age Distribution of the TS-Participants

The age distribution of the TSs, in terms of their ages at the time of their participation in this study, as well as their ages when their UPs and/or TOPs occurred, is depicted in in Table 4.1 below.

Table 4.1: Age distribution of the TS-participants at the time of their participation in this study and when the UP and/or TOP occurred

Participant	Age of participant at the time of the study	Age of participant when the UP and/or TOP occurred
A	30	28
B	19	19
C	22	22
D	22	21
E	21	20
F	20	20

All the TS-participants, with the exception of Participant A, fell into the age group generally referred to by the literature as adolescence and/or late adolescence (Isdale et al., 2016; Jordán-Conde et al., 2014:356; Sigelman & Ryder, 2006:305; Santrock, 1998:24).

Erikson (1982:65 & 1963:245), a well-known German-American developmental psychologist and psychoanalyst, was one of the first to propose a lifespan model to explain human development. He coined “adolescence” as the fifth stage of his eight-stage psychosocial development model. The life stages in succession and inclusive of adolescence are: infancy, toddlerhood, preschool/early childhood, childhood/middle childhood, adolescence, young adulthood, middle adulthood, and late adulthood (Dunkel & Harbke, 2017:59; Knight, 2017:1049; SAACHDE, 2010:2; Saddock & Saddock, 2003:35). For Erikson, each life stage presents a pair of opposing psychological tendencies which need to be balanced (Knight, 2017:1049) or, to put it differently, a developmental crisis that needs to be resolved in order to ensure healthy developmental progression, as well as the development of a continuous self/ego (Knight, 2017:1049; Gouws, Kruger & Burger, 2008:79; Sneed, Whitbourne & Culang, 2008:149). Failure to successfully achieve the unique developmental tasks characteristic of a particular stage could result in the individual becoming “stuck” in a specific stage. As a result, movement

towards resolving the developmental crisis connected to the next stage may be hampered. Such individuals may experience relationship challenges and could resort to the development and adopting of substitute behaviours and/or neurotic symptoms to cope with the trauma/pain associated with an unresolved developmental crisis (Dunkel & Harbke, 2017:60).

As described in Chapter One (see Section 1.5.9.1), young people in South Africa are defined as those falling within the age group of 14 to 35 years (South Africa, 2015), with the National Adolescent and Youth Health Policy 2017 (Department of Health, 2017:1) and several other scholars (Isdale et al., 2016; SAACHDE, 2010; Marteleto et al., 2009:353) describing the life stage from age 10 to 19 years as adolescence and 20 to 24 years as late adolescence and/or the youth. The definitions and opinions about the age group that defines adolescence, late adolescence, and young adulthood varies, with some authors (McDonagh, 2018; Curtis, 2015; WHO, 2011:1; Santrock, 1998:24; Erikson, 1963:245) describing adolescence as the life stage from 10 to 12 years up to 18 to 19 years; late adolescence as the life stage from 18 to 20 years up to 22 to 24 years (McDonagh, 2018; Isdale et al., 2016; Jordán-Conde et al., 2014:356; Sigelman & Ryder, 2006:305) and young adulthood as the life stage from 18 to 19 years up to 28 to 40 years (Lane, 2015:30; Levinson, 1986:4; Erikson, 1963:245).

In the context of this study and in adopting the definitions of the aforementioned South African Policies, adolescence and late adolescence is seen as the life stage ranging from 10 to 19 years up to 20 to 24 years, with the age group 25 to 40 years falling in the category referred to as “young adulthood” (Lane, 2015:30).

Participant A, who was 30 years of age when she participated in the study, indicated that she was 28 years old when her UP occurred. This, according to Lane (2015:30) and Erikson (1963:245), places her in the “young adulthood” category which is referred to as the “emerging stage of life” (Lane, 2015:30). This life stage is characterised by various transitions and role changes contributing to periods of crisis and psychological difficulties, leaving some of the young adults in this developmental stage “significantly distressed” (Lane, 2015:30; Tabane & Mmapheko, 2015:2). Elevated distress accompanying transitions have been

shown to increase impulsivity and risk-taking behaviours amongst young adults, posing a considerable threat to their wellbeing (Lane, 2015:30; Tabane & Mmapheko, 2015:2; Daley, 2012:38; Schlossberg, 2011:159).

For the young adult, such as Participant A, the developmental task/crisis that needs to be completed according to Erikson's psychosocial development model is that of acquiring intimacy. Successful completion of this stage can result in happy relationships and a sense of commitment, safety, and care within a relationship. Failure to accomplish this may result in isolation, loneliness, or depression (Dunkel & Harbke, 2017:60; Lane, 2015:30; Sigelman & Ryder, 2006:311).

When reflecting on the chronological ages of Participant B, C, D, E, and F and their ages when their UPs and/or TOPs occurred, as gleaned from Table 4.1 above, it can be seen, as mentioned earlier, that they were in the life stages generally referred to as adolescence and late adolescence. These life stages are seen as transitional between childhood and adulthood (Lane, 2015:30; Gouws et al., 2008:40; Burman, 1994, in Macleod, 2003:419) with several scholars describing it as extremely developmentally challenging (Jordán-Conde et al., 2014:356; SAACHDE, 2010:4).

One of the major life transitions emerging at the end of Matric that is unlike any other previous childhood transition, is moving away from the childhood home, the family of origin, and an established network of friends to pursue tertiary education (Lenz, 2001:302) or find employment. This resonates with Schlossberg's view (in the Transition Process Model adopted as theoretical framework for the study – see Section 1.4) that transitions imply change and put into motion efforts to adjust or adapt to the transition experienced (Schlossberg, 2011:159). It is emphasised that a successful transition from adolescence to adulthood will impact positively on the future stages of development and transitions (Lenz, 2001:302; Schlossberg, 1981:7).

Several authors state that the general age range for the majority of young people who make the transition from secondary education to tertiary/higher education is between 17 and 20 years of age (Isdale et al., 2016; Marteleto et al., 2009:351;

Schleicher et al., 2009:507-508). This suggests that TSs, on average and according to life stage development, find themselves in adolescence or late adolescence (Bhorat et al., 2015; Saddock & Saddock, 2003:35; Lenz, 2001:302).

The conflict central to the adolescent life stage is that of “identity formation” versus “identity confusion” (Dunkel & Harbke, 2017:59; Knight, 2017:1049; SAACHDE, 2010:2; Saddock & Saddock, 2003:35). Even though this life stage is generally focussed on career matters and romantic relationships, it is the crystallisation of identity that takes centre stage (Jordán-Conde et al., 2014:356-357; SAACHDE, 2010:2). It is during this life stage where the adolescent grapples with the questions “who am I?” and “what is my place in the world?” Self-image construction is actively pursued by integrating the view that they have of themselves and the views others have of them into the self, and by acquiring skills and taking on of roles correlating with their vision and/or plans for the future (Gouws et al., 2008:79). The active searching for self and experimentation characteristic of this phase ultimately establishes a positive sense of self or ego identity, with the individual aspiring to have a clear internal sense of self, sense of self in relation to others, and sense of self in relation to life and the world (SAACHDE, 2010:3). Failure to reach these aspirations will result in “identity diffusion” (Saddock & Saddock, 2003:214) and the lack of a clear self-identity, or an unrealistic or negative self-identity. Several authors (Gouws et al., 2008:81; Sigelman & Ryder, 2006:29; Saddock & Saddock, 2003:215; Santrock, 1998:26) aver that in this life stage adolescents dabble in or engage in high-risk sexual behaviour, substance abuse, eating disorders, extreme rebelliousness, and/or conflict with authority figures. They experience difficulties in establishing and ending relationships; encounter study and work-related challenges; and might experience confused sexual identity. All of these manifestations may be traced back to the lack of clear positive self-image.

Apart from the developmental task of acquiring a realistic and positive self-image, adolescents have to tackle and complete various social, financial, academic, and personal developmental tasks, as well as overcome complexities and challenges related to these. Several authors (Isdale et al., 2016; Sharma, 2012:34-35;

Schleicher et al., 2009:510; Berman, Strauss & Verhage, 2000:1; Tomoda, Mori, Kimura, Takahashi & Kitamura, 2000:248) highlight the following in this regard:

- Social developmental tasks and complexities: managing the developmental task of separation from parents and family (especially when relocating to another province or city to pursue tertiary studies); forming and establishing new relationships (both friendship and romantic relationships); and experimenting and dealing with both the opportunities and challenges that come with exposure to greater freedom and that of being a student. This refers to the possible exposure to and experimenting with alcohol and/or other chemical substances, intimate sexual exploration and exploitation, and the possibility of contracting STDs or becoming pregnant unintentionally.
- Academic developmental tasks: acquiring responsible time management regarding class attendance; learning how to manage academic pressure and schedules; and negotiating the many facets of life in order to meet academic goals.
- Financial developmental tasks: acquiring the skills of responsible financial management and managing the stress and realities related to the lack of financial support/resources.
- Personal developmental tasks: the achievement of personal independence, the integration of sexuality into one's identity, and the emergence of a separate person with one's own values and goals.

When casting these developmental tasks and complexities into the context of being a TS, Sharma (2012:33) states that TSs are under extreme pressure to define themselves whilst measuring up to their own expectations, as well as those of their professors, parents, and peers. Adding to this, the numerous transitions accompanying the adolescent life stage to which adolescents have to adjust or adapt would require from them a certain amount of resilience, self-knowledge, and stability in personal views, values, and behaviours (Lane, 2015:33, 36; SAACHDE, 2010:4).

In reflecting on the ages of the TS-participants, especially their ages when their UPs and/or TOPs occurred, Johnson and Madise (2010:3) remark that individuals in the adolescence, late adolescence, or young adulthood developmental life stage

are more likely to be at risk for UPs when compared to older (35 years or older) women. Johnson and Madise's observation, together with the age range from the TS-participants from my study, corroborate the findings of a study conducted by Naidoo and Kasiram (2006:343) at the Westville Campus of the University of KwaZulu-Natal, South Africa, with the purpose of investigating why an increasing number of students were presenting with UPs. They found that 83% of the 30 participants interviewed were between the ages of 19 and 22 when they presented with UPs.

Pregnancies amongst females in the age group of 13 to 21 years of age, according to Garenne, Tollman and Kathleen (in Naidoo & Kasiram, 2006:343), account for one third of all pregnancies in South Africa. Naidoo and Kasiram (2006:343) furthermore reveal that many young women, especially young Black women from traditional rural communities who in the past would have gotten married and had children whilst in the adolescent life stage, are today delaying marriage in order to pursue a tertiary education. These young women however "continue to remain sexually active, thus falling pregnant and extending the adolescent period into their twenties" (Villarreal, in Naidoo & Kasiram, 2006:343). This sentiment confirms Macleod's (2003:421) viewpoint that a factor such as extended schooling could very well extend the age of an individual; in other words, tertiary education could extend the dependency of an individual and by implication also the life stage (adolescence/late adolescence) of said individual to an age beyond the chronological age defined for this specific life stage.

4.2.2 Participants' qualifications enrolled for, year of study at the time of participating in the study and year of study in which the UP and/or TOP occurred

Table 4.2 contains information on the qualifications the TS-participants are enrolled for, their year of study at the time of participating in this research study, as well as the year of study in which their UP and/or TOP occurred.

Table 4.2: Participants' qualifications enrolled for, year of study at the time of participating in the study, and year of study in which the UP and/or TOP occurred

Participant	Qualification enrolled for	Year of study at the time of this study	Year of study when UP and/or TOP occurred
A	Financial Information Systems	4 th Year (Honours)	2 nd Year
B	B. Ed (Education)	2 nd Year	2 nd Year
C	B. Ed (Education)	3 rd Year	3 rd Year
D	LLB (Law)	4 th Year (Final)	3 rd Year
E	Human Resources Management	3 rd Year	2 nd Year
F	B. Com (Information Systems)	2 nd Year	2 nd Year

Participant C and D were in their third year of study when their UPs and/or TOPs occurred, while the other participants all were in their second year of study when it occurred. No participants were in their first year or their final year of study when the UP and/or TOP occurred.

These findings differ slightly from the findings of Naidoo and Kasiram (2006:343) in their exploration of UPs amongst university students. Of the 30 students who participated in their study, 47% were in their first year and 33% were in their second year of study when they fell pregnant. Only 3% were in their final year of study when their unplanned pregnancies occurred. The authors concluded that in the initial years (the first or second year) of their studies, students appeared to be less concerned with or more ignorant regarding contraception and/or pregnancy prevention (Naidoo & Kasiram, 2006:343) and that the older/more mature students seemed to be “more conscientious about their studies” (De Bryn & Joubert, 2002, in Naidoo & Kasiram, 2006:343), taking precautionary measures to prevent UPs.

Ibisomi and Odimegwu (2007:64) conducted a secondary data analysis of the 1998 South African Demographic and Health Survey (SADHS). The latter was a nationally representative cross-sectional survey with a probability sample of 12 000 women between the ages of 15 and 49. Ibisomi and Odimegwu's (2007:64) study population consisted of 1 395 South African female youth, aged 15 to 24 years, from all nine provinces in South Africa. They utilised a structured questionnaire to collect information on fertility issues and the factors or critical

predictors associated with UPs, such as age, marital status, region, education, and relationship with last sexual partner, amongst the South African youth. Their findings confirmed high levels of unintended pregnancy in the age group 15 to 24 years, with 71% of their respondents indicated that their pregnancies were unplanned. They furthermore found that “the likelihood of unintended pregnancy increases as the educational level of a young women increases” and that “women with higher education were significantly more likely to experience unwanted pregnancy than women with lower levels of education” (Ibisomi & Odimegwu, 2007:74). They concluded that women in the age group of 20 to 24 years presenting with UPs are the ones most affected by this phenomenon, as this is normally the age during which young women are either in formal employment or busy with tertiary education and this age group is often considered as “incompatible with childbearing and rearing” (Ibisomi & Odimegwu, 2007:74).

In another South African study, the trend of UPs amongst women with Grade 12 or a higher educational qualification was also noticed. Naidoo, Zungu and Hoque (2013:342) conducted a cross-sectional descriptive study by means of a self-administered questionnaire among 103 sexually active females between the ages of 18 and 49, with the purpose of investigating awareness, utilisation, and barriers regarding the use of emergency contraception to address the high levels of unwanted pregnancies. More than half of their participants (58.6%) indicated that they had attained Grade 12 (Matric) or a tertiary qualification as their highest level of education (Naidoo et al., 2013:343).

These trends mentioned are in contradiction to the view held by Mothiba and Maputle (2012:19) who state that “unintended pregnancy are found commonly amongst young people who have been disadvantaged and have poor expectations with regard to their education.”

4.2.3 Place of residence of TS-participants during their studies and when their UP and/or TOP occurred

The information related to the participants’ place of residence during their studies and when their UP and/or TOP occurred is presented in the table below.

Table 4.3: Place of residence of TS-participants during their studies and when their UP and/or TOP occurred

Participant	Institutional Accommodation		Private Accommodation
	Residence	Flat/Commune	
A			X
B	X		
C	X		
D	X		
E	X		
F		X	

From Table 4.3 it becomes clear that Participant B, C, D, E, and F resided in accommodation provided by the tertiary institutions, while Participant A, who was enrolled for a post-basic degree qualification, stayed in private accommodation not provided by the tertiary institution she attended. Participant A mentioned that she spent her first year of tertiary studies in a university residence, but that she moved to private accommodation – a private flat – during her second year of study, which was also the year in which her UP occurred.

University accommodation is generally considered as safe³⁷ and convenient with residences/flats/communes usually being on, relatively close to, or within walking distance of the campus. Each tertiary institution has, in this regard, its own set of rules/regulations³⁸ that prescribes/explains expectations with regard to student behaviour, initiation and orientation procedures, and residence activities, to name but a few.

It seems that the place of residence while studying has little/no influence on the occurrence of an UP and/or TOP. One would assume that the prevalence of this phenomenon would be higher amongst day students (with private, off-campus accommodation being associated with more freedom and independence as

³⁷ University accommodation is generally supported by 24-hour security, access control, and support services such as assistance with/referral for medical attention in case of a medical emergency.

³⁸ An example of a rule/regulation in this regard can be found in the Residence Rules and Regulations of Tertiary Institution D (2015:31; 2012:28), where I am employed) which state that pregnant students are allowed to reside in a residence only until the end of their fifth month of pregnancy, at their own risk. Similar rules/regulations apply at other institutions of higher education.

opposed to the relatively stricter rules and regulations associated with university accommodation), but the findings of this study indicate otherwise.

4.2.4 Province and Area where the TS-participants came from originally

In Table 4.4 the province and area where the TS-participants came from originally are indicated.

Table 4.4: Province/area where TS-participants came from originally

Participant	Province	Area		
		Urban	Semi-urban	Rural
A	Gauteng	X		
B	KwaZulu-Natal		X	
C	Mpumalanga			X
D	North West & Gauteng		X	
E	Limpopo & Gauteng		X	
F	Gauteng		X	

From the table it becomes clear that the participants originated from a mix of geographical areas in their respective provinces. Participant B, D, E, and F labelled the geographical areas they were originally from as “semi-urban”³⁹. Participant A mentioned that she grew up and resides, when not at university, in an urban area. Participant C regarded her place of residence when not at university as “rural”.

Many, if not most, research studies being conducted about the sexual behaviour of and/or the prevalence of UPs and/or TOPs amongst individuals in the adolescence, late adolescence, or young adult life stages seem to be focused on urban populations (Fotso, Izugbara, Saliku & Ochako, 2014; Kaaya, Flisher, Mbwambo, Schaalma, Aarø & Klepp; 2002:153). The importance of a distinction

³⁹ The term “**urban area**” refers to towns, cities, and suburbs. It could be described as the region surrounding a city and is normally very developed (in other words, it consists of a density of human structures, such as houses, commercial buildings, roads, bridges, railways, etc.) (*Cambridge Online Dictionary*, n.d., sv “urban”). A **rural area**, in contrast, is seen as the opposite of urban and described as a countryside or geographic area that is located outside towns and cities. Rural areas typically have a low population density and small settlements (*Cambridge Online Dictionary*, n.d., sv “rural”). A **semi-urban area** is described as somewhere between urban and rural, or partly urban with the difference between semi-urban areas and rural areas being the development of the geographic area and environment (*Cambridge Online Dictionary*, n.d., sv “semi-urban area”).

between these groups in the presentation of research findings is however emphasised by the mentioned authors as it could, amongst others, be an indicator of subtle variations in sexual permissiveness and/or the attitudes and norms of said populations towards aspects such as sexual intercourse and peer pressure.

Ibisomi and Odimegwu (2007:74), in their study (elaborated upon in Section 4.2.2) on the predictors of unintended pregnancy among South African youth, state that region⁴⁰ as a variable can be described as a predictor of sexual and contraceptive behaviours, as well as one of the critical forecasters of UPs. These scholars quote Eggleston (in Ibisomi & Odimegwu, 2007:64) who is of the opinion that “area and region of residence are strongly associated with pregnancy intention”. Their research findings indicated that 81% of South African youth respondents with UPs were from KwaZulu-Natal, followed by the Eastern Cape (75%). The Northern Cape (66%) and the North West Province (56%) had the lowest percentage of UPs, with the other five provinces having percentages of between 68% and 71% (Ibisomi & Odimegwu, 2007:73). These findings correspond with the findings of other studies consulted (Mchunu et al., 2012:431; Patel & Kooverjee, 2009:562; Naidoo & Kasiram, 2006:342; Manzini, 2001:44-45; Craig & Richter-Strydom, 1983:452), which all made reference to the high rates of UPs among young women in KwaZulu-Natal.

For Johnson and Madise (2010:4) the community in which a woman resides plays a significant role in determining the risk of having an UP and significantly modifies her contraceptive behaviour. While these authors claim that there may be differences in the occurrence of UPs between urban and rural women, with the latter being more prone to UPs due to lack of resources to meet their contraceptive needs (Johnson & Madise, 2010:2), the research they conducted in which they examined geographical variation in the risk of UPs among Ghanaian women (adolescents, late adolescents, and young adults) revealed that the “variance estimates for urban and rural communities were not statistically significant” (Johnson & Madise, 2010:4). Ibisombi and Odimegwu (2007:74) through their

⁴⁰ Region, in the context of Ibisomi and Odimegwu’s study (2007:67), refers to the nine provinces in South Africa. Each province furthermore is characterised by urban, semi-urban, and rural areas, elaborated upon in the previous footnote.

research refute the claim made with reference to such differences and mention the availability of family planning services offered across areas as possible reasons for this finding (Hoque & Guman, 2012; Johnson & Madise, 2010:6; Ibisomi & Odimegwu, 2007:74).

4.2.5 Ethnicity and language distribution of the TS-participants

Participant A identified herself as Coloured while the rest of the participants indicated their race as Black. No students from the Indian or White racial groupings participated in this research study. The ethnic distribution in my study matches that of the respondents in Ibisomi and Odimegwu's (2007:67) study (elaborated upon in Section 4.2.4). Ethnically speaking, 86.57% of the respondents with UPs in their study were Black, 11.82% were Coloured, and the White and Indian/Asian respondents with UPs who participated accounted respectively for 0.61% and 1%. Ibisomi and Odimegwu (2007:74), 18 years ago, describe this finding as "not surprising as the pattern of socio-economic opportunities among the ethnic groups follow the opposite direction, with the Whites having the highest and the Blacks having the lowest opportunities." These ethnic distributions also match those of the participants in a study conducted by Mbelle, Mabaso, Setswe and Sifunda (2018:512). They examined the potential predictors of UPs among 1002 female students aged 18 to 24 years, registered at Technical and Vocational Education and Training (TVET) colleges in South Africa and although ethnicity was not identified by them as a factor that might predispose South African youth to high rates of unintended pregnancy, they did report that 88.6% of their participants who reported to have experienced an UP were Black, 5% were White, 5.5% were Coloured, and 0.9% were Asian/Indian.

All of the participants in this research study furthermore indicated that English was not their first/home language. Participant B indicated that her home language was isiZulu, Participant A was Afrikaans-speaking, Participant C stated that her first language was siSwati, two of the participants (Participant D & F) indicated that their home language was Sesotho, while Participant E indicated that her home language was isiXhosa. All of the participants however, being registered students at institutions of higher education, confirmed that they were fluent in English and

that they were comfortable with me conducting the research interview with them in English.

The presentation of the biographical information on the TS-participants is herewith concluded. A discussion of the themes, sub-themes, and categories that emerged from the data analysis process will now be presented.

4.3 THE THEMES, SUB-THEMES, AND CATEGORIES THAT EMERGED FROM THE DATA ANALYSIS PROCESS

The data obtained from the semi-structured, in-depth, face-to-face interviews conducted with the TS-participants were thematically analysed by myself and an independent coder. The framework as proposed by Tesch (in Creswell, 2014:198) was used for the purpose of thematically analysing the data. On completion of the activity of data analysis, the study's supervisor facilitated a consensus discussion where the independent coder and I had to present the themes, sub-themes, and related categories that emerged and where these were consolidated.

Table 4.5 presents an overview of the themes, with their accompanying sub-themes and categories.

Table 4.5: Overview of the themes, sub-themes, and categories that emerged from the data analysis process as consolidated during a consensus discussion

THEME ONE: CIRCUMSTANCES LEADING UP TO, AND THE FEELINGS, EMOTIONAL REACTIONS, AND LIFE CHANGES EXPERIENCED FOLLOWING THE UP-EXPERIENCE	
SUB-THEMES	CATEGORIES
Sub-theme 1.1: Participants' accounts of the nature of their relationships prior to the UP	–
Sub-theme 1.2: Participants' explanations of the reasons for their UPs	Category 1.2.1: Lack of contraceptive use; negative attitudes about condom use; and the incorrect risk assessment about falling pregnant as explanations provided for UPs
	Category 1.2.2: Stopped using contraceptives because of the side-effects and the failure of the contraceptives used as reasons given for the UP
	Category 1.2.3: God knew that the participant needed somebody in her life to nurture due to the person she was as reason given for the UP
Sub-theme 1.3: Feelings and emotional	Category 1.3.1: Feelings of shock, denial, and

reactions experienced on confirmation of the suspicion of the UP	disbelief experienced on confirmation of the suspicion of the UP
	Category 1.3.2: Feeling worried and stressed on confirmation of the suspicion of the UP
	Category 1.3.3: Feelings of fear of loss of the relationship with their partners and significant others experienced on confirmation of the suspicion of the UP
	Category 1.3.4: Feelings of guilt and shame experienced on confirmation of the suspicion of the UP
	Category 1.3.5: Feelings of loneliness experienced and withdrawal/isolation from others on confirmation of the suspicion of the UP
	Category 1.3.6: Feelings of disappointment and sadness experienced on confirmation of the suspicion of the UP
	Category 1.3.7: Feelings of anger experienced on confirmation of the suspicion of the UP
	Category 1.3.8: Mixed feelings experienced on confirming the suspicion of the UP
Sub-theme 1.4: Participants' accounts of how their lives changed following the UP	Category 1.4.1: The UP forced a participant to grow up and become responsible
	Category 1.4.2: Participants' relationships with significant others ended and/or became strained
	Category 1.4.3: Participants' financial prospects became uncertain and caused stress
	Category 1.4.4: Participants' academic performance deteriorated and academic progression became uncertain as result of the UP
THEME TWO: PARTICIPANTS' ACCOUNTS OF THE DECISIONS TAKEN TO DEAL WITH THE UP, WHAT INFORMED THEIR DECISIONS, AND THE FEELINGS AND EMOTIONAL REACTIONS EXPERIENCED AFTERWARDS	
SUB-THEMES	CATEGORIES
Sub-theme 2.1: Participants' decisions taken in dealing with their UPs	–
Sub-theme 2.2: Participants' accounts of the factors that influenced the decision taken in order to deal with the UP	–
Sub-theme 2.3: Feelings and emotional reactions experienced following the decision taken in order to deal with the UP	–
THEME THREE: PARTICIPANTS' ACCOUNTS OF THE NATURE OF THE SUPPORT RECEIVED IN RELATION TO THEIR UPs AND/OR TOPs, HOW THEY EXPERIENCED THIS SUPPORT, AND HOW THEY WOULD HAVE LIKED TO BE SUPPORTED OTHERWISE	
SUB-THEMES	CATEGORIES
Sub-theme 3.1: Participants' accounts of the on- and off-campus professional and informal support sought and received	–
Sub-theme 3.2: Participants' accounts of how they experienced the on- and off-campus professional and informal support sought and received	Category 3.2.1: Positive experiences related to the on- and off-campus professional and informal support sought and received
	Category 3.2.2: Negative experiences related to the on- and off-campus professional and

	informal support sought and received
Sub-theme 3.3: Participants' accounts of what they would have liked to be different in terms of the on- and off-campus professional and informal support sought and received	Category 3.3.1: A participant would have liked to have more information about the on- and off-campus support services available to her
	Category 3.3.2: Participants would have liked to have more support from their significant others
	Category 3.3.3: Participants would have liked to have more information about the different options available when dealing with an UP
	Category 3.3.4: Participants would have liked to be better prepared for the TOP-process and procedure
	Category 3.3.5: A participant would have liked to be less afraid of what she believed others were thinking or saying about the ordeal of her UP
THEME FOUR: SUGGESTIONS FOR PSYCHOSOCIAL SUPPORT TO TSs PRESENTING WITH AN UP AND/OR TOP	
SUB-THEMES	CATEGORIES
Sub-theme 4.1: Participants' suggestions for medical and counselling support, peer support and education, awareness campaigns, as well as academic-related support to students with UPs and/or TOPs and suggestions to students to utilise this support	Category 4.1.1: Suggestions for medical support offered to students presenting with an UP and/or TOP
	Category 4.1.2: Suggestions related to counselling support, peer-support and education, and awareness campaigns for students presenting with an UP and/or a TOP
	Category 4.1.3: Suggestions for academic-related support to students presenting with an UP and/or a TOP

In the next section of this chapter, the first theme with its accompanying sub-themes and categories will be presented and illustrated, underscored, and/or confirmed by the provision of direct quotations from the transcripts of the semi-structured, in-depth, face-to-face interviews that were conducted with the participants.

4.3.1 Theme One: Circumstances leading up to, and the feelings, emotional reactions, and life changes experienced following the UP-experience

This theme emerged from the following request made to the participating TSs during the semi-structured, in-depth, face-to-face interviews I had with each of them: *“Please describe to me, in as detailed a manner as possible, your situation when you experienced your UP.”*

In addition, I used the following probing requests and questions:

- What would you say were the reasons for your UP?
- Share with me what your personal circumstances were at the time of your UP?
- Think back and share with me the feelings/emotions that you experienced when you realised that you were pregnant?

Afterwards I continued by requesting that each of the students individually share with me how the UP that she experienced changed her life.

In spotlighting the participants' circumstances leading up to their UPs and the reasons given for their UPs against Schlossberg's model for analysing human adaptation to transition, also known as the Transition Process Model (Anderson et al., 2012:30; Schlossberg, 2011:159; Schlossberg, 1981:2), introduced in Chapter One (see Section 1.4) as the theoretical framework for this study, the following needs to be mentioned. The suspicion and/or confirmation of an UP for many TSs is a crisis, a major life-event stressor, or a highly traumatic event, disrupting the equilibrium of the students' academic, social, relational, and family life, as well as future career prospects (Barton, Redshaw, Quigley & Carson, 2017; Tabane & Mmapheko, 2015:1; Daley, 2012:39; Adams & Williams, 2011:1879-1880; Van Breda, 2011:4; 'Lanre, 2010:197; Skinner et al., 2009:52; Sodi, 2009:18). This crisis event rings in a transition or turning point resulting in imminent and fundamental changes in their relationships, their outlook on life, and their self-image (Tabane & Mmapheko, 2015:2; Daley, 2012:39; Turner, 2011:134; Van Breda, 2011:4; Schlossberg, 1981:25). The disequilibrium caused by the UP needs to be arrested in that the student has to work out ways of handling the crisis. This, to paraphrase Weiss (1976, in Schlossberg, 1981:6), will involve the summoning of the individual's resources in order to either arrest the crisis and return to the pre-crisis stage, or to embark on re-organisational change.

Schlossberg (1981:15) states that how an individual deals with a crisis and the transition that follows, and proceeds towards adapting or integrating the transition into their lives is dependent on their perceived or actual appraisal of assets and/or liabilities or deficits in terms of the **Situation**, the **Self**, **Support**, and coping

Strategies (referred to as the 4S-system in Schlossberg's Transition Process Model) (Anderson et al., 2012:10; Schlossberg, 2011:160-161). Appraising the *situation* in terms the context in which the event (the UP) occurs and the impact of the event on the individual (the *self*), as well as the convoy of *support*, can be regarded as taking stock of what is available in the pre and post-transition stages. The *strategies* relate to taking charge, by summoning intrapersonal coping resources and coping strategies, as well managing established sources of support and/or identifying and enlisting new sources of support and coping strategies to change/reframe and adapt to the situation or transition (Workman, 2015:5; Anderson et al., 2012:38; Schlossberg, 2011:160).

This theme on the circumstances leading up to and the feelings, emotional reactions, and life changes following the UP-experience thus ties in with the aspect of the “*situation*” in the 4S-system of Schlossberg's Transition Process Model (mentioned above). This theme branched into four sub-themes with sub-themes 1.2 to 1.4 further divided into categories. The sub-themes and categories (where applicable) will now become the focus of the discussion.

4.3.1.1 Sub-theme 1.1: Participants' accounts of the nature of their relationships prior to the UP

In sharing the situation related to their UP-experience, four of the participants voluntarily shared information about the nature of their relationships prior to the occurrence of their UPs, which is provided below.

“I was involved with somebody and... we'd be seeing each other for about a year... not a very committed relationship, but we would see each other on occasions and we would see each other when we could and so forth...” [Participant A].

“I've been with my boyfriend for a long time now... almost two years...” [Participant B].

“...last year September my fiancée and I... we started talking about... having a baby... I thought about it and I thought... OK... I should pray about it... whether it’s the correct thing to do right now since I’m not yet done with my studies... then I just sort of left it... then, ag, I just sort of, we stopped talking about it. Then, in December, you know what we normally do... we take risks [referring to having unprotected sex]...” [Participant F].

“...I’d been dating him for almost seven years now so I was, it was someone that I thought, well I still think... you know, we’ve known each other for quite a while, we are comfortable with each other, we’re from the same sort of backgrounds, you know, our parents know about the relationship and everything and he’s working, he’s stable...” [Participant D].

Apart from Participant A, Participant B, D, and F all perceived their relationships as long-term and being relatively stable and committed. Participant F even spoke about talk between her and her partner about starting a family. Participant C and E did not, at this stage of the interviews conducted with them, volunteer information about their relationships⁴¹.

Although the hypothesis, namely that unmarried young women or women not living with their partners are more likely to experience an unintended pregnancy, has been confirmed by several authors and research studies (Haffejee, O’Connor, Govender, Reddy, Sibiya, Ghuman, Ngxongo & Borg, 2018:80; Bafana, 2010:12; Abiodun & Balogun, 2009:147; Ibisomi & Odimegwu, 2007:63; Naidoo & Kasiram, 2006:348), it is also stated that UPs very often occur in stable, long-term relationships (Mbelle et al., 2018:512). The role of specific relationship characteristics, such as time spent together, stability and intensity of the relationship, couple identity, living arrangements, sexual activity and number of partners as other predictors of unintended pregnancies (Barber, Kusunoki, Gatny

⁴¹ The reader is advised to revisit the tabulated overview in Chapter Three (Table 3.2): the observational notes shared about the interviews that were conducted with the TS-participants indicated that Participant C and E were nervous and emotional during the interviews, they had difficulty in expressing themselves, and both of them were referred for debriefing/follow-up counselling. Participant C did, later in the interview (see Sub-theme 1.3, Category 1.3.3 in this chapter), share her feelings of fear that her boyfriend might leave her if she informs him about her UP.

& Yarger, 2010:4) is consequently highlighted, as it has been found that “measures of the seriousness of young women’s relationships are strong predictors of their risk for UP and that time-intensive and exclusive relationships are particularly likely to produce unintended pregnancies” (Barber et al., 2010:13)

In the next theme the reasons offered by the participants for the occurrence of their UPs are presented and discussed.

4.3.1.2 Sub-theme 1.2: Participants’ explanations of the reasons for their UPs

After consulting various literature sources, I indicated the following factors as contributing to the phenomenon of UPs (see Section 1.1.1.2):

- Ignorance about and negative attitudes towards contraception, and negative experiences in this regard (Coetzee & Ngunyulu, 2015; Christofides et al., 2014; Mchunu et al., 2012:427; Seutlwadi et al., 2012:46; Sekgobela, 2008:3; Naidoo & Kasiram, 2006:345; Benokraitis, 2005:319).
- Gender inequality, where men still exert power over women sexually (Jewkes et al., 2010:43; Wood et al., 1998:237) complicating some women’s ability to negotiate and demand condom use (Jewkes et al., 2010:43; Mwaba & Naidoo, 2005:651).
- Risk-taking behaviour, drug and alcohol abuse, and engaging in unprotected sex despite being knowledgeable about the risk of an UP or contracting STDs (Seutlwadi et al., 2012:45-46; Patel & Johns, 2009:502; Patel & Kooverjee, 2009:560; Wechsberg et al., 2009; Badenhorst et al., 2008:112).
- Giving in to peer pressure and participating in sexual relationships that may lead to UPs, especially where unprotected sex is practiced (Calvert et al., 2013; Sieving et al., 2006:13; Kirby 2002:474).
- Limited access to resources and information, and lack of sex education by parents on safe sex practices (Coetzee & Ngunyulu, 2015; Mchunu et al., 2012:432; Macleod & Tracey, 2009:31; Naidoo & Kasiram, 2006:345).
- Poverty and educational disempowerment (Mchunu et al., 2012:427; Akintade, Pengpid & Peltzer, 2011:74; Dinkelman et al., 2008:54; Scharwächter, 2008:192; Kaufman et al., 2004:262).

From the participants' explanations of the reasons for their UPs, three categories emerged and will be presented next.

- a) Category 1.2.1: Lack of contraceptive use; negative attitudes about condom use; and the incorrect risk assessment about falling pregnant as explanations provided for UPs

Participant D unequivocally stated that **not using any contraceptives and practising unprotected sex led to her UP**: *"Simple... I didn't use protection... [laugh]. That's the reason why I fell pregnant; I can't even declare it any further than that. ...I'm a smart student who... what... I know better than other people [laugh] so I knew exactly why it happened..."*

The trend of engaging in unprotected sex that eventually results in an UP is reported by several scholars (Coetzee & Ngunyulu, 2015; Adams & Williams, 2011:1876; Miller, 2011:69; Abiodun & Balogun, 2009:147; Panday et al., 2009:31; Ibisomi & Odimegwu, 2007:78; Naidoo & Kasiram, 2006:348-349).

Negative attitudes about the use of condoms led to the occurrence of Participant B and C's UPs. Participant B in her account not only mentioned that she and most of her peers do not like to use condoms during sexual intercourse, but also provided her reason for her and her partner's non-condom use that ultimately led to her UP. She shared the following: *"All of us, most of my friends, about 90% of them, when I talk about sex... we say: 'Ah... na... I don't like condom'... Honestly, I don't like to use the contraception because I... I don't have a baby [yet]... it [contraception]... it affects the eggs... it decreases the level of you falling pregnant. It's better if you prevent after you have a baby because now you have a baby, you see. And then you have higher chances of getting another baby"* [Participant B].

Participant C also shared what led to her UP: *"My boyfriend, he does not like the condom..."*

These negative attitudes towards condom use amongst the youth, despite its benefits, are confirmed by several scholars. Tabane and Mmapheko (2015:1) conducted an investigation into the perceptions of female teenagers in the Tshwane District of the Gauteng Province, South Africa, on the use of contraceptives. They found that even with participants being aware of the importance of contraceptive use for pregnancy prevention, the motivation to obtain contraceptives and/or use it committedly was lacking. Their participants displayed a predominantly negative attitude towards the use of contraceptives and harboured unfounded fears around its use (Tabane & Mmapheko, 2015:6). Ibisomi and Odimengwu (2007:63) note that adolescents and young adults often internalise the negative messages and attitudes held by their peers about condoms. Participant B and C's accounts provided above attest to this. Macleod and Tracey (2009:v) hold a similar view, stating that whilst condoms are regarded to be the most popular form of contraception amongst adolescents and young people, the usage thereof is influenced and prevented by peer norms and attitudes, and gender power relations and inequalities.

This negative attitude about condom use, in part, may be attributed to the moral high ground taken by healthcare professionals and family planning nurses who cast negative judgements on and scold young women who try to obtain condoms and other contraceptives that are to be distributed freely. The provision of incorrect or inadequate information on the correct use of contraceptives by these healthcare practitioners has also been reported as another factor feeding into the youths' negativity about condom use (Adams & Williams, 2011:1880; Mathews, Guttmacher, Flisher, Mtshizana, Nelson, McCarthy & Daries, 2009:189; Panday et al., 2009:32; Patel & Kooverjee, 2009:558; Wood & Jewkes, 2006:109). It is therefore not surprising that Coetzee and Ngunyulu (2015:7) admit that "inadequate knowledge and awareness on some contraceptive methods exist". This was one of the conclusions drawn from their study amongst 400 female undergraduate students in a selected higher educational institution in Gauteng, South Africa, to assess the use of contraceptives amongst the respondents.

The influence of the peer group on sexual behaviour and contraceptive use should not just be cast in a negative light. Several authors aver that when positive

perceptions amongst the members of a peer group prevail, especially around the use of condoms, those members are more likely to use condoms and contraceptives (Baird & Porter, 2011:152; Corkin, 2011:4; Panday et al., 2009:36; Sieving et al., 2006:13; Kirby, 2002:475). With this said, the importance of the peer group should never be underestimated, especially during adolescence, as friends and peers are regarded as trusted and sometimes even the primary sources of information when it comes to sexual intercourse, contraception use and preferences, and STIs and other communicable diseases (Adams & Williams, 2011:1882; Abiodun & Balogun, 2009:147; Panday et al., 2009:37; Ibisomi & Odemegwu, 2007:63).

Apart from the lack of contraceptive use and negative attitudes about condom use preventing the use thereof as reasons provided for the UPs experienced by the participants of my study, Participant B, D, and F also **attributed the occurrence of their UPs to the perception that they were not at risk of falling pregnant**. The quotes below illustrate this.

“...and it never came to my mind that I can become pregnant... because of the previous experiences... maybe you sleep with a guy and you don’t fall pregnant, so you think: ‘Aahh, I cannot fall pregnant’...” [Participant B].

“... there’s this myth that I don’t believe in anymore, because I can testify to it that... you know... my friends and I think, you know, normally when you’re just done with your periods... you’re not ovulating so you can’t fall pregnant and that’s what happened to me” [Participant D].

“Ag, maybe it’s not going to happen but... it happened, I just didn’t think it would be me” [Participant F].

Participant B, D and F’s perceptions of not being at risk of falling pregnant are echoed in the findings of Skinner et al.’s (2009:55-56) Australian study in which they explored the perceptions, attitudes, and experiences of female adolescents with regard to pregnancy and protection. According to them, a commitment to pregnancy prevention is “firmly located within the perception of pregnancy risk”

(Skinner et al., 2009:50). Their findings revealed that many of their participants had dismissed the risk of becoming pregnant for various reasons. The most prominent reason provided was the prevailing perception that because they previously engaged in unprotected sex and did not fall pregnant, it would not happen this time around. The explanations provided by my participants (quoted above) correspond with the retrospective descriptions offered by the participants in Skinner et al.'s study. These are: "I didn't think it would happen..."; "[Pregnancy]... is something that only happens to people that want it to happen or that plan it to happen"; and "It was in my mind but you just think it will never happen... Because you get away with it [referring to having unprotected sex] a couple of times and it doesn't happen and then it does" (Skinner et al., 2009:50). Other researchers conducting studies amongst the youth about condom use in order to prevent pregnancy or the transmission of STIs disclosed that many of their participants did not perceive themselves to be at risk of getting pregnant or contracting HIV (Osario, Lopez-del Burgo, Ruiz-Canela, Carlos & De Irala, 2015; Adams & Williams, 2011:1878; Miller, 2011:68; Panday et al., 2009:31).

Several scholars (Nsubuga, Sekandi, Sempeera, & Makumbi, 2016; Adams & Williams, 2011:1881; Miller, 2011:68; Rosen, 2010:28; Panday et al., 2009:32; Skinner et al., 2009:51; Sekgobela, 2008:22) profess that this perception about not being at risk of experiencing an unintended pregnancy, especially prevalent amongst the youth, is the result of a lack of information; ignorance; prevailing myths; and non-contraceptive use.

Amongst the prevailing myths that put young people at risk of experiencing an UP and making them careless about pregnancy prevention methods are the beliefs that conception only occurs during menstruation; that irregular periods provide a physical barrier that prevents the occurrence of a pregnancy; or that unprotected sex during or just after menstruation will not result in a pregnancy (Adams & Williams, 2011:1883; Panday et al., 2009:32; Skinner et al., 2009:52; Wood & Jewkes, 2006:111). Adding to this, and regardless of the plethora of information available about conception and contraception, is the prevailing ignorance and gaps in information and knowledge about human physiology how one can become pregnant, and/or how it could be prevented (Nsubuga et al., 2016; Baird & Porter,

2011:151; Abiodun & Balogun, 2009:147; Skinner et al., 2009:53; Sekgobela, 2008:25; Bankole et al., 2007:201).

In summary, Kirby (2007:14) stresses that young people who perceive themselves to be at risk of an UP are more likely to adopt protective measures and/or behaviours.

- b) Category 1.2.2: Stopped using contraceptives because of the side-effects and the failure of the contraceptives used as reasons given for the UP

Participant F shared how she stopped using contraceptives because of her negative experience with her chosen contraceptive: *“I was [using contraception and referring to the use of the contraceptive pill] but then I stopped because they had a bad effect on me...”*

It is not uncommon for contraceptives to have side-effects on individuals. For some, hormonal contraceptives may cause nausea, moodiness, and weight-gain, and in the case of condoms, reduce sexual enjoyment (Bafana, 2010:25-26; Bello et al., 2010:5; Abiodun & Balogun, 2009:148). However, Skinner et al. (2009:54) warn that while for some individuals these side-effects might be real, others may refuse to use the contraceptives based purely on the information obtained from those who experienced the side-effects. These authors also mention that the main reason for not using or stopping the use of contraception is often based on fear of the side-effects, especially with regard to new contraceptives being introduced to the market.

Scepticism regarding the efficacy of contraception, such as the belief amongst some young people that a condom alone is not sufficient to prevent pregnancy, also influences the decision on whether or not to use contraceptives. For some contraceptives to be effective, a certain amount of discipline is required, as is the case with taking oral contraceptives (also known as the pill). This may be negatively perceived as a barrier or obstacle to effective contraceptive use (Nsubuga et al., 2016; Baird & Porter, 2011:153; Panday et al, 2009:31; Patel & Kooverjee, 2009:559; Skinner et al., 2009:53).

Three of the TS-participants in my study declared that **their UPs occurred as a result of contraceptive failure**. The quotes below illustrate this.

“...I was on the three-month injection and we used a condom and I took the morning-after pill afterwards... and I still got pregnant...” [Participant A].

“I ... [became] pregnant unexpectedly. So... I used... the tablets to prevent... for, from getting pregnant and he [referring to her partner] went to the traditional... traditional doctors, if you know, to get some, some medications and to be stronger than my, my tablets that I was drinking. So, in that way I got pregnant” [Participant C].

The practice of involving traditional medicine to either prevent conception or to enhance fertility is not uncommon (Panday et al., 2009:32) and incidents involving traditional medicine to prevent pregnancy, or to prove/improve fertility, are still being reported (Nsubuga et al., 2016; Panday et al., 2009:32; Ratlabala et al., 2007:29).

“It wasn’t a matter of using a condom. It, it’s like... I think the condom just burst” [Participant E].

Concerns around and scepticism about the safety of contraceptives, not only condoms, but also injections and oral contraceptives, to prevent unintended pregnancies have been reported in the literature consulted, especially given the fact that despite the use of contraceptives, unintentional pregnancies occurred (Osario et al., 2015; Miller, 2011:69; Patel & Kooverjee, 2009:558; Skinner et al., 2009:53).

Bafana (2010) conducted a study in Potchefstroom, a town in the North West Province of South Africa. This cross-sectional retrospective survey conducted among 1121 women of reproductive age (18-49) aimed to investigate the adverse outcomes of pregnancy by occupation, social class, urbanisation, maternal risk factors, and pesticide exposure. This researcher found that 16% of the 59.7% of his participants who experienced an UP reported that they became pregnant whilst

using contraception (Bafana, 2010:31). In a Pennsylvanian study, conducted by Miller (2011), in which the knowledge and attitudes of 692 undergraduate college students regarding emergency contraception were explored, it was found that over 83% of the college students who participated in her study indicated that despite the availability and use of contraceptives, they “feared that at one time or another they or their partners were pregnant” (Miller, 2011:4).

- c) Category 1.2.3: God knew that the participant needed somebody in her life to nurture due to the person she was as reason given for the UP

This category emerged from the explanation provided by Participant A when she was prompted about the reason for the occurrence of her UP. She explained: “...*I can definitely... say that things don't just happen for a... for any reason... there's a specific reason why... you fall pregnant, in certain situations... I believe that, from a Christian's point of view, from my spiritual point of view, I believe God knew I needed somebody in my life, something to nurture, because that's the type of person that I am...*”

She arrived at this conclusion and insight, as she still felt pregnant despite the fact that she utilised three contraceptives – an injection, the condom, as well as emergency contraception (commonly known and referred to as “the morning-after pill”). Being a very religious/spiritual person led her to believe that her UP was *supposed* to happen as part of a higher intention, purpose, or plan for her life.

The role of moral and/or religious values or beliefs, specifically with regard to contraception, pregnancy, and/or TOP, seem to be of particular importance in this regard and is emphasised by several authors (Osario et al., 2015; Baird & Porter, 2011:153; Patel & Kooverjee, 2009:559; Badenhorst, 2005:96). According to Skinner et al. (2009:53), some young people who are confronted with an UP adopt a fatalistic attitude of “if it was going to happen, it was going to happen” (Skinner et al., 2009:53). Even though the UP might be characterised by ambivalence, these statements (including and also referring to the statement from the participant above) could be indicative of an acceptance of a higher intention to accept the

reason and/or purpose behind the occurrence of the UP (Baird & Porter, 2011:154; Skinner et al., 2009:53).

In concluding this sub-theme of participants' explanations for the reasons for their UPs, it must be noted that although several international studies found that young females have the ability to assess their risk of pregnancy fairly well, negative attitudes towards contraceptive use, ignorance, and carelessness significantly increase the risk of an UP (Nsubuga et al., 2016; Coetzee & Ngunyulu, 2015:5; Tabane & Mmapheko, 2015:6; Miller, 2011:71; Aujoulat, Libion, Berrewaerts & Noirhomme-Renard, 2010:449; Patel & Kooverjee, 2009:557; Skinner et al., 2009:56; Sekgobela, 2008:23; East, Khoo & Reyes, 2006:188; Bruckner, Martin & Bearman, 2004:249). Participant F admitted to this same level of carelessness when she stated: *"Me and my boyfriend were too careless."*

In the next section, the feelings and emotional reactions experienced on confirmation of the suspicion of the UP are presented and discussed.

4.3.1.3 Sub-theme 1.3: Feelings and emotional reactions experienced on confirmation of the suspicion of the UP

Casting this sub-theme into Schlossberg's Transition Process Model (1981:6), this author postulates that any transition event (such as an UP), or even a non-event, is rich in feelings and emotional reactions being experienced (cf. Mnyango, 2015:17; Schlossberg, 2011:159; Evans et al., 1998:111).

From the participants' accounts following my request to *"Think back and share with me the feelings/emotions that you experienced when you realised that you were pregnant"*, I came to the conclusion that they experienced a smorgasbord of negative feelings and emotional reactions upon suspecting and after confirmation of their unintended pregnancies. These feelings and emotional reactions are now presented as categories.

- a) Category 1.3.1: Feelings of shock, denial, and disbelief experienced on confirmation of the suspicion of the UP

The following disclosures made by the participants point to the feelings of shock, denial, and disbelief experienced on confirmation of the suspicion of the UP:

“At first it came as a shock. It was just unbelievable” [Participant A].

“...but I didn’t want to accept it, you see that thing – Ahh, I’m not pregnant...”
[Participant B].

“...it was first of all shock... I didn’t believe it...” [Participant D].

“I was like... You know what... I didn’t even want to know what’s going on...”
[Participant F].

Despite the inconsistent and/or incorrect use of contraceptives to prevent unintended pregnancies, the discovery of an UP is generally experienced by young women as a shocking or even a “highly traumatic event” (Ekstrand, Tydén, Darj & Larsson, 2009:175). The initial feeling of shock is frequently followed by a mixture of other emotions, such as denial or disbelief (Akbarzadeh, Yazdanpanahi, Zarshenas & Sharif, 2016:190; Adams & Williams, 2011:1879-1880; Skinner et al., 2009:52; Arhin & Cormier, 2008:212).

- b) Category 1.3.2: Feeling worried and stressed on confirmation of the suspicion of the UP

After the initial shock of having the suspicion of an UP confirmed, young women often experience feelings of worry and stress. They tend to worry about the reactions of parents and partners when they disclose their UP-status and they experience stress about their futures, studies, and finances, as well as the impact that the unintended pregnancy might have on their relationships with their parents and partners. Several scholars aver that feelings of apprehension and stress and grappling with questions such as *“Should I tell my partner?”*, *“What are my*

options?”, “What will the impact of this pregnancy be on my studies and my family?”, “Will I be able to provide for this child?”, and “Am I mature enough to be a parent?” are normal and common in this situation (Barton et al., 2017; Steck, 2011:17-18; Ekstrand et al., 2009:176; Skinner et al., 2009:52; Arhin & Cormier, 2008:214; Holmberg & Wahlberg, in Holmberg & Wahlberg, 2007:43).

The storylines below are provided in substantiation of this category.

“I am a student... maybe they [referring to her parents] will say I must drop out and stay home and look after my baby... I was so worried... I am not working... how will I take care of a baby? When I realised, ‘eish, I’m pregnant’... I stressed after that...” [Participant B].

“I was so worried, you know, I got really thin, like I got... I lost weight... and I was thinking... ‘What about my career?’... ‘What about my life?’” [Participant C].

“You know, this was supposed to be the year where I leave university... you know, with a bang. And then... this... I worried and I was so down...” [Participant D].

“...I have stress... who, about who’s going to take care of my child...” [Participant E].

Later in the interview Participant E made reference to other worries and concerns she had, when stating: *“...my parents [what they would say] ...Because they are too [so] proud of me. I’m their first-born child and they just expected too much from me. So it would really be like a disappointment. You never know, what if they disown me or something. ‘Cause they don’t expect such thing from me but then, I guess things happen...”*

“... and I worried... because I literally thought my life has ended completely because of this... I was like... this kid is going to take my life away from me...” [Participant F].

Participant F, also in reflection, stated that she was worried about her mother’s reaction: *“...mum – what is – how is she going to react to this whole... thing*

because I'm still at school? Because I always feared that what if she says – about the baby.”

The fear of disappointing and/or angering parents when disclosing a confirmed UP as articulated by some of my participants in the storylines provided above, is confirmed in the literature consulted (Barton et al., 2017; Adams & Williams, 2011:1881; Ekstrand et al., 2009:175; Patel & Kooverjee, 2009:559; Skinner et al., 2009:53; Arhin & Cormier, 2008:212; Panday et al., 2009:27; Naidoo & Kasiram, 2006:341; Badenhorst, 2005:96).

In addition to the feelings of worry, stress, and concern upon the confirmation of the suspicion of the UP, the TS-participants also experienced feelings of fear that they might lose relationships with some of their significant others. These feelings are presented as the next category.

c) Category 1.3.3: Feelings of fear of loss of the relationship with their partners and significant others experienced on confirmation of the suspicion of the UP

In an ideal world, friends and family would become sources of emotional and practical support when a young woman is confronted with the reality of an UP. However, and for various reasons, this is often not the case. If the young woman is an unmarried student, informing her partner and parents, as significant others, about the UP becomes extremely difficult, if not impossible, because of the fear that she might lose these significant relationships (Tabane & Mmapheko, 2015:2; Van Breda, 2011:20; Ekstrand et al., 2009:176; Arhin & Cormier, 2008:213; Panday et al., 2009:27; Naidoo & Kasiram, 2006:341).

The feelings of fear experienced by the participants in view of disclosing their UP-status to their significant others are evident from the storylines below.

“I was afraid... about what people would say... I was so scared... What do I tell my parents? What do I tell my friends? What do I tell my – my... my boyfriend, because I know he wasn't ready...” [Participant A].

“...I was so scared of my mom... Of what she would say because... I haven’t finished my degree and now I’m pregnant so I was scared of what she will say... my parents... what are they going to do because I’m a student... maybe they will say I must drop out... and my boyfriend... because if he knew that I was pregnant... maybe he was going to leave me for that... Many... girls when they fall pregnant... their boyfriends leave, leave them and I thought that my boyfriend would just leave too...” [Participant C].

“It’s not easy... I haven’t even told my friends...” [Participant E].

“When I found out that I’m pregnant I kept quiet... it was just... I’m scared of being judged... if, maybe, he [referring to her boyfriend] was going to leave me. I thought he was going to leave me... I’m really relying on my boyfriend. What if he decides to just go?” [Participant F].

The feelings of fear, especially for young unmarried women confronted with an UP, is exacerbated by the possibility of not only being judged negatively by her peers and family, but also being isolated, deserted, or ostracised by them. Additionally, upon disclosure of the UP a young woman may lose her standing in her community; be removed from a leadership position she might have had in the tertiary institution community; and even be stigmatised as someone who is immoral and promiscuous (Akbarzadeh et al., 2016:191; Van Breda, 2011:22; Ekstrand et al., 2009:176-177; Skinner et al., 2009:52; Panday et al., 2009:27; Sekgobela, 2008:2; Naidoo & Kasiram, 2006:341).

d) Category 1.3.4: Feelings of guilt and shame experienced on confirmation of the suspicion of the UP

Guilt is a feeling that is experienced when a person believes or perceives that what they did was wrong (Mpshe, Gmeiner & Van Wyk, 2002:72). Apart from the guilt conjured up by the experience of an unintended pregnancy, feelings of shame are also often experienced by the woman in such a situation (‘Lanre, 2010:197). The feelings of guilt and shame might be the result of her perception that her peers and parents disapprove of the pregnancy due to cultural, moral, and/or

religious convictions. As an UP announces the reality of a young woman's sexual activity, feelings of guilt and shame may surface, especially if she wanted to keep her sexual activities a secret. The UP by implication means that she let her significant others down and lost her virginity in what they may perceive as an undignified manner, which either ignites or fuels the feelings of guilt and shame (Barton et al., 2017; Akbarzadeh et al., 2016:191; Adams & Williams, 2011:1882; Wilks & Spivey, 2010:279; Ekstrand et al., 2009:175; Arhin & Cormier, 2008:213; Sekgobela, 2008:90; Mpshe et al., 2002:72).

Participant A and B's accounts below serve as testimony of the feelings of guilt and shame experienced as a result of their UPs.

"How could I let this happen? What will everybody think of me? ...my parents, my community, back home... I just wanted to hide, I didn't want anyone to know..." [Participant A].

"So I was thinking... my mom... she will be so sad and disappointed... She has many plans for me and now... How will I face people? ...What will they think? ...I must just stay in my room..." [Participant B].

Confirmation of the suspicion of the UP also caused five of the six participants to experience feelings of loneliness and caused them isolate and withdraw from others. This aspect is elaborated on next.

- e) Category 1.3.5: Feelings of loneliness experienced and withdrawal/isolation from others on confirmation of the suspicion of the UP

The utterances from the participants presented below gave rise to this category.

"...and loneliness... that I'm going through this alone... is there any, anybody that's going to help me...?" [Participant A].

"...I didn't want them [referring to her friends and fellow students in the residence] to come to my room; I was like avoiding them. I had these moods, you see... [at

first] *I was alone 'cause I didn't want to tell anyone about this so I was like spending lot of time on my own. When my boyfriend wants to come to me, I didn't want to talk to him. By this time, I didn't... haven't told him anything...*" [Participant B].

"...when my friend [referring to a female friend who was studying with her and also staying in the same residence] is not around I feel very lonely" [Participant C].

"Then I ended up breaking up with my boyfriend, then I just went through the whole thing alone" [Participant E].

"...because I was feeling quite lonely and unsupported... I kept on closing people out, because I just knew ... I just thought that I'll be alone, no one is going to help me. So I was like – there's no use in me telling anyone" [Participant F].

The literature consulted confirms these feelings of loneliness as well as the tendency to withdraw or isolate oneself upon confirmation of the UP. This is mainly due to the actual and/or perceived lack of support from significant others (Adams & Williams, 2011:189; Steck, 2011:31; Sekgobela, 2008:92; Ehlers & Netshikweta, 2002:79).

- f) Category 1.3.6: Feelings of disappointment and sadness experienced on confirmation of the suspicion of the UP

It has been argued that an UP could elicit depressive symptoms as it could, *inter alia*, compromise a woman's objectives – in the case of the TS, it could prevent her from successfully completing her studies (Akbarzadeh et al., 2016:192; Aujoulat et al., 2010:448; Bouchard, 2005:620). Bouchard (2005:633) postulates that being confronted with the reality of an UP could conjure up emotions of intense disappointment and sadness, especially as this eventuality blocks the realisation of future plans.

The storylines provided below testify to the participants' feelings of disappointment and sadness experienced on confirmation of the suspicion of the UP.

“I thought my life has ended... I felt very down” [Participant B].

“... when I think about this pregnancy... I cry and I feel very emotional...” “...I cried so much... I felt so sad... I felt disappointed...” [Participant C].

“You know, this was supposed to be the year where I leave university... you know, with a bang. And then... this... I worried and I was so down... I just stayed in my room... I was upset and sad, I felt hopeless... Gosh, I was upset... I was so disappointed, how could I let this happen?” [Participant D].

“And ... I cried. I cried a lot. I cried...” [Participant F].

In confirming this category, several scholars aver that depression; feelings of disappointment, whether it be in herself or for disappointing others such as her parents; and inertia are common emotional reactions experienced when an UP is confirmed (Barton et al., 2017; Van Breda, 2011:3; Arhin & Cormier, 2008:213; Sekgobela, 2008:90).

g) Category 1.3.7: Feelings of anger experienced on confirmation of the suspicion of the UP

From the narratives presented below, in substantiating this category, it becomes clear that the feelings of anger experienced by the two of the three participants who made reference to this were mainly directed at themselves.

“...and anger... I had anger. I was angry at myself for allowing this to happen... when I fully knew that it's not the right circumstances. I was angry at myself for this. I was still angry at myself... because... at the end of the day... why be in a relationship, a sexual relationship, and not be in a committed relationship or even... married... just the whole, the circumstances was... something that I'd prepared, that I did... it was my choice to have those circumstances and... that is why I was angry with myself” [Participant A].

“...I was so angry with myself, with my boyfriend” [Participant B].

“I was so angry with my boyfriend. Ja, I blamed him for, for my pregnancy”
[Participant C].

Experiencing feelings of anger are relatively common amongst young, unmarried women upon confirmation of their UPs, especially if this was due to carelessness, lack of contraceptive use, ignorance about how to use contraceptives correctly, and/or the belief that they were not at risk of falling pregnant. Further fuelling the feelings of anger is the realisation that the UP interferes with and limits their prospects of personal fulfilment in terms of further education and economic stability (Barton et al., 2017; Adams & Williams, 2011:1880; ‘Lanre, 2010:197-198).

A further point worth noting is that women who experience anger (whether it be directed at themselves or at others) as a result of their UPs often experience similar feelings as those of people going through grief (Adams & Williams, 2011:1880; Ekstrand et al., 2009:175; Mpshe et al., 2002:74). Feelings of powerlessness and/or helplessness have also been reported and, according to Adams and Williams (2011:1880) and Mpshe et al. (2002:74), many young women resort to bargaining, saying to themselves “Maybe if I ...” or “What if I...”, voicing statements such as “What if I devote the rest of my life to helping others? Maybe I will wake up and find out that this has all been some terrible dream.” They also resort to blaming themselves, uttering statements like “How could I let myself fall into this pit?” Even the partner, parents, circumstances, or God could be blamed: “It’s all his fault... he promised... he was supposed to have...”

In conclusion, I wish to concur with the view of several authors who state in this regard that anger as a result of an UP often is a reflection of the situation in which the young woman finds herself due to unsupportive significant others (Adams & Williams, 2011:1877; Arhin & Cormier, 2008:215; Mpshe et al., 2002:74).

h) Category 1.3.8: Mixed feelings experienced on confirming the suspicion of the UP

Participant E shared the mixed feelings she experienced after finding out about her UP along the following lines: *“But then... I had mixed feelings... my heart told me [one thing] ...and my mind told me [something else] ...A part of me was, like... happy... but I was also scared... Ja...”*

Several authors acknowledge the fact that an UP often raises a lot of different, sometimes confusing and conflicting feelings and thoughts (Barton et al., 2017; Holmberg & Wahlberg, 2007:50-51). While feelings of anxiety may be experienced because of the fact that the student cannot comprehend having a baby until she has completed her studies or is financially able to support a child, she may at the same time feel scared of or intimidated by the unknown, for example regarding not knowing how to parent. Feelings of joy, excitement, or happiness may also be present, as being a mother and having a child could be something that she has always wanted. The pregnancy might even be regarded as a new opportunity.

It is not uncommon to have mixed and paradoxical feelings about the UP, according to Ekstrand et al. (2009:175). The contradictory feelings and ambivalence experienced and the intensity thereof is, to a large extent, determined by the convoy of support available to them, or the lack thereof (Barton et al., 2017; Ekstrand et al., 2009:175; Skinner et al., 2009:52).

The discussion of the sub-theme on the feelings and emotional reactions experienced on confirmation of the suspicion of the UP is herewith concluded. In the next section of this chapter the sub-theme on how the participants' lives changed as a result of the UP will be presented.

4.3.1.4 Sub-theme 1.4: Participants' accounts of how their lives changed following the UP

Schlossberg's Transition Process Model (Anderson et al., 2012; Schlossberg, 2011; Schlossberg, 1981) (see Section 1.4), the adopted theoretical framework for

this study, is premised on the crisis theory. This author states that an event will only be perceived or regarded as a crisis if it is experienced by the person as such. As indicated earlier in this chapter, the event of an UP is experienced by most TSs as major traumatic life event or stressor (Barton et al., 2017; Tabane & Mmapheko, 2015:1; Daley, 2012:38). This event introduces a transition which, according to Schlossberg (1981:3), inevitably “results in a change in assumptions about oneself and the world and thus requires a corresponding change in one’s behaviour and relationships.” It was for this reason that I wanted to know from the participants how the event of the UP impacted on their lives and I therefore asked them to share with me how their lives changed since the experience of the UP.

Their accounts were translated into categories, to be presented next, as it relates to this sub-theme.

a) Category 1.4.1: The UP forced a participant to grow up and become responsible

Participant A related how her UP forced her to grow up and become responsible: *“...then it was pressures of... now I need to grow up ‘cause I was in the fun mood. I had to become responsible... [the UP] pressures you into making a decision... Is it morally right to have an illegitimate child? ...Would it be best then to have an abortion? But, then again, to have an abortion is also not morally right so it’s – I had a lot of pressures in terms of... what to do and... that was the biggest thing that I had to come to terms with.”*

An UP and/or motherhood/parenthood are viewed and described by many, if not most, adolescents and young people as their worst nightmare (Skinner et al., 2009:52) and something that would rob them of their freedom and studies/career, and prevent them from having fun (Barton et al., 2017; Nelson & O’Brien, 2012:508; Adams & Williams, 2011:1880; Ekstrand et al., 2009:175; Arhin & Cormier, 2008:212). It is furthermore associated with assuming responsibility and becoming an adult which, for many young people, is synonymous with/implies pressure to grow up, settle down, be mature, and leave behind the relatively carefree lifestyle that is often associated specifically with being a student (Skinner

et al., 2009:52; Arhin & Cormier, 2008:213-214; Sekgobela, 2008:32). These pressures can be overwhelming, especially if the individual lacks the necessary coping and interpersonal skills required when dealing with an UP, or when vital support (physical and emotional) is lacking (Barton et al., 2017; Nelson & O'Brien, 2012:508; Adams & Williams, 2011:1880; Ekstrand et al., 2009:176; Philkill & Walsh, 2002:21).

- b) Category 1.4.2: Participants' relationships with significant others ended and/or became strained

Participant A mentioned that after informing her boyfriend about her pregnancy, he ended the relationship. This caused extra pressure and she even contemplated making the child available for adoption. She stated: *"...when I had my three months term and... I finally told everybody and... I told my boyfriend. He then decided that he didn't want to be a part of this – part of our lives, part of... my son's life... the pressure... that came through for me was... being a single mom. Is it something that I want for my son? Maybe it would be better to... give him up for adoption and have him, you know, in a normal family with a dad and a mom..."*

Participant D revealed how her mother and grandmother (who raised her) reacted when she broke the news about being pregnant: *"... and I then I told my mum and she wasn't happy. So those were the circumstances around it and my mum and my grandmother, those were the two people, who raised me, they weren't happy about it."* She also later related the following: *"They [referring to her mother and grandmother] wanted me to have an abortion because... and they really clearly stated it."* This had a damaging effect on their relationship.

Prescriptive behaviour and pressure from significant others (as in the case of Participant D, her mother, and grandmother) on how to manage the UP is confirmed by several scholars (Adams & Williams, 2011:1880; Ekstrand et al., 2009:175; Bhuda, 2008:60; Sekgobela, 2008:93; Naidoo & Kasiram, 2006:345; Bouchard, 2005:634). The behaviour of parents or a partner in this regard tends to be financially, religiously, relationally, or academically motivated. For parents who have high expectations of their child or who have a high social standing in their

community, termination of the pregnancy may be seen as the only option to keep the dreams that they have for their child alive and/or to keep their reputation in tact (Barton et al., 2017; 'Lanre, 2010:197). Pressure from the parents and/or the partner to continue with the pregnancy is perhaps founded on the belief that the TOP constitutes the taking of a life and is thus regarded as a sin. Where a partner who is responsible for the girlfriend's pregnancy is financially unable to provide for the child, he may exert pressure on her to terminate the pregnancy (Nelson & O'Brien, 2012:509; 'Lanre, 2010:197; Ekstrand et al., 2009:176; Arhin & Cormier, 2008:213-214; Naidoo & Kasiram, 2006:344; Bhuda, 2005:60).

In adding to the discourse covered in this category, Adams and Williams (2011:1882), state that an UP has the potential to "negatively impact the quality of important relationships, such as those with family and friends".

To react with anger, panic, indifference, or rejection upon receiving the news of a partner or child's UP is not out of line (Nelson & O'Brien, 2012:509; 'Lanre, 2010:198). Having said this, the reactions of significant others to the news of an UP, the support they offer or refuse, as well as their role in the life of the student is pivotal in that it will have a direct bearing on how she will manage the UP-crisis (Barton et al., 2017; Van Breda, 2011:6; Ekstrand et al., 2009:176; Arhin & Cormier, 2008:213; Mpshe et al., 2002:74-75). A lack of support and/or negative reactions from significant others can feed into feelings of isolation, sadness, anger, and loss, which in turn could result in uninformed or impulsive decisions being taken. She may decide to terminate her pregnancy based on the actual or perceived lack of support available from significant others (Adams & Williams, 2011:1881).

- c) Category 1.4.3: Participants' financial prospects became uncertain and caused stress

Participant A and C's accounts gave rise to this category and are presented below.

"I had to become responsible. I had to make sure that I'm – that I financially grow. Is the job that I'm in... I was busy with my studies, working part-time... in two,

three months when I give birth, is it going to be good enough? ...or maybe I should leave my studies... look for another job with a higher salary... finding stability... you know all those pressures that I had to think of quickly because, I mean, it was only nine months and he was there. So, it was quick decisions that I had to make” [Participant A].

“Ja... financially... my mother is the one who, who gives me money every month for, to buy food and, if it might happen that I, I give birth to that child, she’s the one who’s supposed to take care of it even though my, my boyfriend will support... by giving the food by – she’s the one who have to take care of the child and she is working [as a domestic worker] to give me money to buy food now. So that’s also the stress that I have, because she have to leave work [referring to her concern that her mother might not be able to continue working if she has to look after her baby] ...I don’t know what will happen” [Participant C].

According to Ekstrand et al. (2009:176), most TSs who are confronted with an UP find themselves worrying and stressing about not completing their studies, finding employment and financial stability, and entering into a potentially long-lasting and loving relationship, with the latter being seen as basic necessities for raising a child. As many if not most students are dependent on their parents, partner (to a certain degree), and/or a study loan or bursary for the continuation and completion of their studies, the UP will have an impact on this. The possibility that she may have to interrupt her studies and in so doing forfeit the bursary, or that her significant others may withdraw their financial support, results in the experience of stress. Worrying about care and providing for the child compounds this even further, which leads to the experience of feelings of helplessness in this regard (Van Breda, 2011:3; Ekstrand et al., 2009:176; Parker, 2009:12). Participant C’s account testifies to this fear and uncertainty about child-care when stating: *“There is pressure about who’s going to take care of the baby.”*

Caring for a child that was conceived unintentionally while studying is something that both the student and her parents might find impossible to do (Barton et al., 2017; Van Breda, 2011:4, 23; ‘Lanre, 2010:197, 200; Ekstrand et al., 2009:176; Parker, 2009:12; Naidoo & Kasiram, 2006:344; Mojapelo-Batka & Schoeman,

2003:147). Many parents enter into great financial debt that they can ill-afford and make a lot of sacrifices to pay for their children's education. Caring for their child's child would add more financial pressure, a financial demand that many are unable to meet. The student's partner may also be a student, making it impossible for him to provide for the child (Akbarzadeh et al., 2016:511; Levi, Simmonds & Taylor, 2009:303; Arhin & Cormier, 2008:213-214; Ratlabala et al., 2007:29).

It is for these given reasons that students, although valuing having children, perceive an UP as "a mistake" that would hamper their educational aspirations, as well as their future career and financial prospects (Valois, Zullig, Kammermann & Kershner, 2013:50; 'Lanre, 2010:200; Mojapelo-Batka & Schoeman, 2003:147).

d) Category 1.4.4: Participants' academic performance deteriorated and academic progression became uncertain as result of the UP

The following statement by Mary Ellen Duncan, former President of the Howard Community College (The National Campaign, 2009), confirms that academic pressure as a result of an UP could be quite severe and compelling, as it could distract, delay, or derail students from reaching their educational goals: "Whether the opportunity for education is lost or delayed, unplanned pregnancy often makes life harder for those trying to achieve the 'dream' of a college education."

This statement corroborates the sentiments of several other authors who aver that unintended pregnancy substantially increases the risk of dropping out (Valois et al., 2013:36; Arhin & Cormier, 2008:213; Naidoo & Kasiram, 2006:345). It has been found that 61% of women worldwide who fall pregnant while at college or university fail to finish their diploma or degree (Valois et al., 2013:37; Miller, 2011:69; Skinner et al., 2009:54).

Participant C and E made reference to how their academic performance deteriorated and their academic progression became uncertain as result of the UP, as per their statements below.

“My studies... this year... not going very... so well as last year... I do pass, but with low marks... lower marks; 50, 60...” [Participant C].

“It was only my parents and my studies... 'Cause I didn't want to fall behind, having to repeat maybe the second semester again. Then... my third year, not going to my third year the following year. I just thought I'm gonna fall behind and not have a future” [Participant E].

Coping with academic demands seems to be difficult for students during pregnancy. In such circumstances the female student is unable to function at capacity to keep up, with assignments, readings, and assessments being experienced as challenging (Arhin & Cormier, 2008:213). This seems to be the case during the time when the UP is suspected, as well as upon the confirmation thereof (Barton et al., 2017; Valois et al., 2013:38; 'Lanre, 2010:197).

Perceived lack of faculty and/or institutional support, as well as the perception that most tertiary institutions' policies regarding UPs are not accommodating when a student misses a class, test, or exam as a result of the pregnancy are also observed as a factor adding to the academic pressure experienced by students confronted with the crisis of an UP (Arhin & Cormier, 2008:215).

The presentation of Theme One centring on the circumstances leading up to and the feelings, emotional reactions, and life changes following the UP-experience introduced under various related sub-themes and categories is herewith concluded. In the next theme the focus will be participants' accounts of the decisions taken to deal with the UPs, what informed their decisions, and the feelings and emotional reactions experienced afterwards.

4.3.2 Theme Two: Participants' accounts of the decisions taken to deal with the UP, what informed their decisions, and the feelings and emotional reactions experienced afterwards

This theme emerged from the following requests and questions put to the participants during the interviews I had with them:

- Share with me how you dealt with your UP.
- Tell me about the factors that influenced the decision that you have taken in order to deal with your UP.
- What feelings/emotions did you experience as a result of your decision taken to deal with your UP?

In reflecting on the information that came forward in this regard, I came to the realisation that it relates to the aspect of the “*Self*”, “*Strategies*”, and “*Support*” referred to by Schlossberg in her Transition Process Model (Workman, 2015:5; Anderson et al., 2012:38; Schlossberg, 2011:160) (see Section 1.4) that I adopted as theoretical framework for this study.

For Schlossberg, the aspect of “*Self*” refers to the individual’s inner strength for coping with the crisis situation and to, in the process of transition to adaptation, display a certain amount of resiliency and optimism (Schlossberg, 2011:160). When looking at the decision-making process followed by the TS-participants in dealing with their UPs, they displayed a sense of psychosocial competency which, according to Tyler (1978, in Schlossberg, 1981:12-13), relates to taking responsibility for what happened. They demonstrated behavioural attitudes, such as an active coping orientation and putting a plan into action to deal with the UP.

The aspect of “*Strategies*” (Workman, 2015:5; Schlossberg, 2011:161) refers to the decisions that individuals take in order to cope with the crisis event that happened and the transition it introduced in order to reduce stress. The strategies followed by the TS-participants to deal with their UPs were two-pronged. Some decided to deal with the UP by carrying the child to term and becoming single parents, while others decided to opt for a TOP. How they dealt with UP, against the backdrop of the Transition Process Model framework, can be interpreted as actions taken to restore the equilibrium (Tabane & Mmapheko, 2015:6-7; Daley, 2012:39) and to arrest the crisis (the experience of an UP). The participants who opted for a TOP returned to the pre-crisis stage. The participants who decided to carry the child to term and became single parents embarked, according to Weiss (in Schlossberg, 1981:6), on a re-organisational route and incorporated the changes required in this regard.

Decisions taken on how to arrest a crisis and embark on a transitional route are never taken alone or in isolation. Such decisions are informed and influenced by what Khan (in Schlosberg, 1981:10) refers to as a “convoy of support” or a circle of significant others who inform the ultimate decision taken. From the participants’ accounts, to be presented further down, I will indicate the support provided by their significant others, or the lack thereof, and its influence on informing the decisions taken in order to deal with their UPs.

The theme on the participants’ accounts of the decisions taken to deal with their UPs, the factors that influenced their decisions, and the feelings and emotional reactions experienced afterwards, given the responses of the participants, is presented as three sub-themes to be presented next.

4.3.2.1 Sub-theme 2.1: Participants’ decisions taken in dealing with their UPs

Even when the pregnancy is planned and childbirth and motherhood are associated with positive emotions, pregnancy still remains a stressful life event necessitating important life decisions to be taken and life changes to be made (Geller, 2004:188). In the case where the pregnancy that occurred was unintended, the very delicate decision whether to carry the pregnancy to term or not takes centre stage (Hall, Dalton, Zochowski, Johnson & Harris 2017:1337). The timeframe between when the young woman realises that she is pregnant until such time that a final decision has been reached on how to deal with the UP is a period of intense ambivalence (Kjelsvik & Gjengedal, 2011:169).

An unmarried student who comes to the realisation of her UP finds herself in the midst of a multifaceted crisis for which a solution must be found as soon as possible (Adams & Williams, 2011:1881; Geller, 2004:200). To choose an option from the ones available, namely parenting, adoption, or termination of the pregnancy, in order to deal with the UP crisis is not easy (Likis, 2009:2). Complicating matters even further is the fact that the decision that the young woman/student makes at this point in her life, given her present set of circumstances, may be different from the decision she would have made in another stage or place in her life (Adams & Williams, 2011:1882; Likis, 2009:2).

Regarding how my participants dealt with their UPs, it was indicated that Participant A, B, C, and F decided **to continue with their UPs**. The following utterances attest to this.

“...I chose to... keep my son” [Participant A].

“I decided... I... have to... keep the baby, you see” [Participant B].

“To be truly honest with you, I was going to do abortion... get abortion... [but then] I’ve chosen to stay pregnant” [Participant C]. When asked why she changed her mind in this regard, she indicated that she went for counselling and reconsidered her decision.

“[I decided on] ...keeping the baby...” [Participant F].

Participant D and E decided to **terminate their pregnancies**. Their statements in this regard are listed below.

“I knew that I didn’t want to have an abortion... They [referring to her mother and grandmother] decided – You know, we really think you should have an abortion and ... you should have it tomorrow... so I had an abortion...” [Participant D].

“...had the abortion... I just thought it was the only choice. Like the only thing that can help resolve everything, ‘cause nobody would know... my parents wouldn’t know as well, so they wouldn’t really be disappointed... and then I would just carry on with my life...” [Participant E].

None of the participants opted for adoption as an option to deal with their UPs.

The high rates of TOPs amongst university students as a way of dealing with an UP is noted in all the literature consulted in this regard (Miller, 2011:73; Patel & Kooverjee, 2009:551; Ibisomi & Odimegwu, 2007:62, 73; Naidoo & Kasiram, 2006:348; Varga, 2003:283; Olukoya, Kaya, Ferguson & AbouZahr, 2001:137-138). For the ones who decide to continue with the pregnancy, one or more of the

following considerations seem to play a role: the pregnancy is at a stage too advanced to terminate; parental and/or partner support is available; prevailing cultural and religious beliefs prohibiting a TOP are present; and/or the TOP-process is feared (Frederico, Michielsen, Arnaldo & Decat, 2018:329-330; 'Lanre, 2010:197; Ekstrand et al., 2009:176; Sekgobela, 2008:3; Naidoo & Kasiram, 2006:348; Benokraitis, 2005:498).

I found it quite interesting that none of the participants in this study opted for adoption as an option for dealing with their UPs. This observation seems to be consistent with research findings confirming that carrying a child to term and then giving the child up for adoption is seldom an option considered (Berglas, Williams, Mark & Roberts, 2018:386; Pugh, AN, 2010:15; Badenhorst, 2005:98).

4.3.2.2 Sub-theme 2.2: Participants' accounts of the factors that influenced the decision taken in order to deal with the UP

Participant A, B, C, and F (accounts provided below) disclosed the **factors influencing their decision to continue with their UPs**. In a nutshell, the factors influencing this decision were their own Christian/spiritual beliefs; the advice received from a counsellor; having the support of family and friends; and their partners' advice to not terminate the pregnancy. The quotes below illustrate this.

"When I decide to do something, I do it, but my spiritual life has a big impact on my decisions... what I do... I must admit... the counsellor [referring to the support that she received from a counsellor at a CPCC] had a big part to play in it [referring to the decision to continue with the UP]... and then I would say the support from my family and my friends... was also a big... had an impact on my decision on keeping my son and even things that I do" [Participant A].

"I think [laugh] he [referring to her partner] was suspecting that... I might do the abortion, so he just considered – 'You are pregnant?'. And then I said, 'Yeah, I'm pregnant, then what?'. 'I see you are up to something, you are always alone, you avoiding me, don't you think to do abortion, 'cause you don't know whether it's your first child or your second... Maybe God decided to give you one child, if you

do abortion, you'll never get another baby” [Participant B]. Later on in the interview, Participant B remarked: “... *because my boyfriend... [said], ‘I always wanted a baby with you... I don’t mind to be a father, but you still young to be parent’ ...I mean now I’m happy...[reflecting]... I think them all – my boyfriend, my friends... they all played a role in my decision...*”

“I told my friend... that... I’m pregnant and I wasn’t ready... she gave me advice that I should not do that [referring to TOP] because maybe this child is the only child that God may have given to me...” [Participant C].

“Well... the first thing was myself... and the other thing is he’s [referring to her partner] very Christian [laughs] – so the other thing is ... there’s a part of me that knew that he is NOT going to say ‘abort the baby’, because of his beliefs” [Participant F].

When turning to literature to find support for what the participants presented as factors influencing their decision to continue with the UP and to not opt for TOP, several scholars maintain that the nature of the relationship with the student’s partner/boyfriend, her relationships with significant others such as friends, parents, and family members, and the perceived or real emotional, financial, and practical support received from them will inform and strengthen her decision to continue with the UP (Frederico et al., 2018:34; Kjelsvik & Gjengedal, 2011:172; Rosen, 2010:23; Badenhorst, 2005:94). Naidoo and Kasiram (2006:344) emphasise that while most parents tend to react negatively when coming to know about their child’s UP, there are some who accept the pregnancy and offer support.

From Participant B and F’s accounts it became evident that their boyfriends convinced them not to terminate the pregnancy, but to continue with the pregnancy. These accounts latch on to the findings of a study conducted by Patel and Johns (2009:498) with 141 undergraduate students at the University of KwaZulu-Natal, South Africa, with the purpose of examining gender roles and attitudes to abortion. They found that although the male participants acknowledged abortion as a solution to an UP and that choosing to terminate an UP is the woman’s choice, they were advocating for a joint decision in this regard. In

addition, they were of the view that the partner or boyfriend should have the right to prevent the girlfriend from terminating the pregnancy (Patel & Johns, 2009:502).

Interspersed in the storylines quoted above are references to “spirituality”, “God”, and being “very Christian”. These references, made by Participant A about herself, by the boyfriends of Participant B and F, as well as a friend in the storyline quoted from Participant C, all disclose pro-life sentiments. Such beliefs, that can either be labelled as “moral” or “religious”, irrespective of whether they are the values or beliefs of the pregnant woman, her significant others, or the community, could tip the scale in favour of the decision to carry the UP to term (Ekstrand et al., 2009:176; Arhin & Cormier, 2008:213).

Several studies conducted on the topic of the impact of religiosity on abortion attitudes confirm that religion plays a significant role in the lives of most South Africans (Patel & Johns, 2009:496; Sahar & Karasawa, 2005:289-290). High levels of religiosity, specifically with regard to abortion, have been found in studies conducted amongst South African university students (Patel & Johns, 2009:496; Patel & Myeni, 2008:744; Naidoo & Kasiram, 2006:348; Roothman, Kirsten & Wissing, 2003:214-215). TOP is still viewed by many as a “sin against God” punishable by difficulty/impossibility to conceive again in future (Patel & Kooverjee, 2009:560; Arhin & Cormier, 2008:213; Badenhorst, 2005:95-97) and this belief has been found to play a significant role in many women’s decision to continue with their unintended pregnancies.

When turning to literature to support Participant A’s remark that, “*I must admit ... the counsellor* [referring to the support that she received from a counsellor at a CPCC] *had a big part to play in it* [referring to the decision to continue with the UP]”, Kjelsvik and Gjengedal (2011:173) and O’Reilly (2009:596) emphasise that counselling, guidance, and support that is non-coercive by nature and accurately presents the available options have been proven to promote a carefully considered, well-informed decision for the woman confronted with an unintended pregnancy

Participant D and E's accounts below unveiled the **factors influencing their decision to terminate their UPs**.

Participant D explained: *"They [referring to her mother and grandmother]... wanted me to have an abortion... and they really clearly stated it... my mum was telling me she's not going to pay for my fees anymore, I'll just stay home and everything and I'm thinking, 'oh my word, I have to finish my degree'... and who's going to pay for me if my mum says she's not going to pay for me because of this?"* Later in the interview with me, she further elaborated that the fear of not being able to realise her dream of becoming a lawyer and her peers completing their studies also directed her in the direction of a TOP. *"...Ag, it was just the pressure of... my peers are completing their degrees and I'll be home, you know, I'll be a mother and my dreams of being a lawyer all have vanished. I think that was the other pressure; my education."*

Participant E expounded: *"First of all, it was my parents. I don't want to disappoint them and I wasn't ready for a baby yet as well, I wanted to finish my studies..."*

In turning to literature to find support for the factors mentioned by Participant D and E as informing their decision to terminate their pregnancy, the Guttmacher Institute⁴² (n.d.) states that "abortion has become a readily used option for women facing an unplanned pregnancy" with approximately 40% of all pregnancies worldwide (an estimated 80 million per year) being unintended (Frederico et al., 2018:330).

Steck (2011:17) states that "abortion is present in every culture and within all ethnicities" and that, typically, women who choose to terminate their pregnancy often share some of the following characteristics:

- They are single or unmarried.
- They often are from a lower socio-economic background.
- They decide on TOP early in the pregnancy, usually in the first trimester.

⁴² The Guttmacher Institute was founded in 1968. It is a leading research and policy organisation committed to advancing sexual and reproductive health and rights in the USA (www.guttmacher.org).

This author further mentions that the likelihood of abortion seems to be greater among African women; women who are enrolled at a tertiary institution, or those who have some college education (Steck, 2011:17). Supporting the latter part of Steck's viewpoint, several South African scholars note that although South Africans in general have negative attitudes towards the termination of a pregnancy, TSs, and more females than males, are actually quite approving of abortion (Patel & Johns, 2009:494; Rule, 2004:4). Young women frequently cite concerns about the effects of UPs on future life course outcomes, including education, employment, and relationships, as reasons for choosing to terminate an unintended pregnancy (Frederico et al., 2018:330; Ramathuba, Khoza & Netshikweta, 2012:3; Steck, 2011:15; Fergusson et al., 2007:6).

When scrutinising Participant D's account of the factors influencing her decision to opt for TOP, I arrived at the conclusion that this was not just an impulsive decision to get rid of the problem of the UP, but that the pressure from her mother and grandmother played a significant role in her decision, especially after her mother's threat to withdraw her financial support and not pay for her studies any longer. Several scholars confirm that for many young unmarried women the decision to terminate an UP is often influenced by the attitudes of their significant others and prevailing social norms (Frederico et al., 2018:330; Ekstrand et al., 2009:173; Arhin & Cormier, 2008:212; Fergusson et al., 2007:6; Badenhorst, 2005:87). Such attitudes cause many a student to terminate their pregnancies, as they might feel persuaded or even forced to do so after disclosing their UPs to their significant others (Frederico et al., 2018:329-330; Lohan, Cruise, O'Halloran, Alderdice & Hyde, 2011:1512; Arhin & Cormier, 2008:213).

Although I failed to explore the reason for Participant D's mother's outright negative response to her UP, I want to speculate about the possible role that cultural pressure might have played in this regard, as in some African cultures it is not considered acceptable for an unmarried female to fall pregnant, especially when she is studying at university, often at great cost to the family (Naidoo & Kasiram, 2006:344).

An intense fear of being turned away or shunned, as well as the worry and fear of disappointing their significant others (such as in Participant E's case) could lead to the feeling of being "forced to choose between family and her unborn child" and is therefore often used by many young women as a justification for their decision to terminate the UP. Bhuda (2008:60) states in this regard that women who are forced to terminate a pregnancy against their will might experience greater difficulties in dealing with the emotional impact as well as possible physical implications that they might experience later in life as a result of the TOP (Kjelsvik & Gjengedal, 2011:174; Ekstrand et al., 2009:177; Arhin & Cormier, 2008:213).

Where an unintended pregnancy interferes with the realisation of career goals and dreams, such as in the case of Participant D who stated that the UP caused her dream of becoming a lawyer to vanish, and Participant E who wanted to finish her studies at any cost, TOP is seen as a mitigating solution for the educational disadvantage associated with early/unintended pregnancy and a protector of students' educational and future career opportunities (Frederico et al., 2018:329-330; Miller, 2011:69; Steck, 2011:17-18; 'Lanre, 2010:200; Ekstrand et al., 2009:176; Patel & Johns, 2009:497; Arhin & Cormier, 2008:214; Mojapelo-Batka & Schoeman, 2003:147).

Adding to this is the viewpoint held by Ekstrand et al. (2009:176) that very few young women confronted with an UP are financially able to raise a child on their own.

Apart from Participant E not wanting to disappoint her parents by not finishing her studies, an accompanying factor that influenced her decision to opt for a TOP was her honest confession that she was not ready for a child, or to put it differently, the responsibilities of motherhood. It is not uncommon, when confronted with the reality of an UP, for a young woman to wonder how this event will change the course and direction of her life's journey or to feel that she is too young or not mature enough to meet the requirements of motherhood (Frederico et al., 2018:330; Steck, 2011:18; Ekstrand et al., 2009:176; Abiodun & Balogun, 2009:146).

In summary of this sub-theme, the decision to terminate a pregnancy is never easy. It involves multiple factors and is seldom a decision that rests solely with the pregnant female. Various pressures and/or people have been found to be influential in this decision-making process, with the latter generally being characterised by severe emotional turmoil (Frederico et al., 2018:337-338; Kjelsvik & Gjengedal, 2011:173; Arhin & Cormier, 2008:213).

4.3.2.3 *Sub-theme 2.3: Feelings and emotional reactions experienced following the decision taken in order to deal with the UP*

Participant A, B, C, and F experienced mostly **positive feelings following the decision taken to continue with the pregnancy**. The particulars in this regard are reflected in the storylines below.

Participant A stated: “...so my whole life, at this stage, is about him [referring to her baby]... I think... relief... in the sense that... I knew that keeping my son was the best and would make me happy in the long term.”

Participant B simply mentioned: “Now I’m happy.”

Participant C explained it as follows: “I’ve accepted that what has happened is done. I have to live with the circumstances... I’m starting to like... the child... I’m really enjoying it. Ja. Not always, but sometimes when I think that I’ll be the mother even though I was not ready but it... feels very happy.”

Participant F remarked: “Now I really... I’m get... I’m getting used to it. Because now... you can feel it moving inside you, like – my gosh, it’s real!” Later in the interview she mentioned: “I’m just trying to stay as positive as I can, because right now there’s no time to be negative...”

In turning to literature to support the feelings expressed by the participants above, it seems that their utterances could be indicative of a resignation to accept the unavoidable (Hall et al., 2017:1338; Adams & Williams, 2011:1891; Skinner et al., 2009:54), a confirmation that the decision taken was the right one, and the decision (parenthood) resulting in feelings of relief, contentment, happiness, and

even awe (Tach, Mincy & Edin, 2010:189; Parker, 2009:50; Arhin & Cormier, 2008:213).

When focussing on the participant's feelings and emotions experienced following the decision to continue with the pregnancy in terms of Schlossberg's Transitional Process Model (Schlossberg, 2011:160-161; Anderson et al., 2012:10), it is safe to say that Participant A, B, C, and F succeeded and coped with the transition towards becoming mothers and progressed from a stage of being totally preoccupied with the UP to integrating this transition into their lives (Schlossberg, 1981:7). This translates to adaptation to transition.

The predominantly positive feelings and emotional reactions experienced by my participants who decided to continue with their pregnancies are in contrast to the feelings of resentment, fear, depression, anger or uncertainty, especially regarding the future, which has been cited by various scholars to be prevalent in women with an UP who choose parenthood ('Lanre, 2010:197; O'Reilly, 2009:601; Bouchard, 2005:619).

The accounts of Participant D and E (quoted below) regarding the **feelings and emotional reactions experienced following their decision to terminate their pregnancies** were predominantly negative and in sharp contrast to the participants who decided to continue with their pregnancies. These participants seemed to have perceived the experience of their TOP as a life-changing event, characterised by negativity and distress (Steck, 2011:18; Mpshe et al., 2002:72).

Participant D, after I enquired about how it made her feel that her mother was so angry about the UP and forced her to go for an abortion, disclosed the following: *"Betrayed... I felt really bad and... I don't know why at that time I couldn't tell anyone, I just kept quiet and I didn't tell anyone and I just let it be. I let them take that decision and sort of influence me towards thinking that it's the right thing, 'cause they were like – 'you know, we'll never mislead you, you will be thankful... that we suggested this. At the end of the year you'll see'. And I felt really bad because my boyfriend was really excited and he was supportive and he was willing to take on the responsibility and his parents were also excited and I really felt bad... I didn't want to do it... I felt like they [referring to her mother and*

grandmother] were hypocrites because what they taught me was what they were going against... that's what I thought." She mentioned her emotional state in the days leading up to the TOP: "I didn't eat, I didn't want to see anyone." She also made reference to feeling guilty: "Guilt... About having an abortion behind my boyfriend's back, because they said I shouldn't tell him. They said I should tell him that... the pregnancy test was faulty... 'cause he was also very against it [the idea of a TOP]... and... regret. Mmm, sad – all the bad feelings. I cried most of the time... I felt anger, hatred towards them, resentment. ...I think to some extent I still do resent them... 'cause I didn't talk to anyone about it until after it happened and then I felt like I was losing my mind then I had to talk to someone... I just felt... disappointed and betrayed and hurt. Disbelief, I thought I was dreaming actually."

Participant E elaborated as follows: "Then I ended up breaking up with my boyfriend, then I just went through the whole thing alone... I can just say, once you've just found out that you're pregnant your boyfriend can just abandon you... at any time from there. That's, it's true when they say: 'they just run away after they find out that... that you're pregnant' ...Oh, it was a hectic, terrifying process...". After being silent for a moment she continued: "I can just say... I regret doing, having the abortion... 'Cause it affects you afterwards... you gonna keep on thinking, what if the baby... that was your first and maybe the last baby... what if... maybe [the TOP] damages you in the inside... physically... and it also... affects you... mentally as well... it can cause you to be depressed and then not concentrating... with your work at school and you just not have a social life, 'cause you're going to be busy thinking about it so you're just gonna push everybody away..."

While I am cognisant of the fact that the emotional side effects resulting from TOP vary from one woman to another, and may range from mild regret to full-on depression (Steck, 2011:17; Ekstrand et al., 2009:177; Patel & Kooverjee, 2009:564; Mojapelo-Batka & Schoeman, 2003:150), the following feelings and emotional reactions following a TOP mentioned by several scholars correspond with those experienced by Participant D and E. They point out that feelings of sadness and grief, regret, anger, guilt, shame, loneliness, isolation, and/or withdrawal are common. Women who experienced a TOP may suffer from

insomnia or nightmares, loss of self-confidence, relationship problems, depression, anxiety, post-traumatic stress, and eating disorders (Kjelsvik & Gjengedal, 2011:173; Ekstrand et al., 2009:177; Reardon, Cogle, Rue, Shuping, Coleman & Ney, 2003:1253; Mpshe et al., 2002:76).

Several scholars (Steck, 2011:18-19; Ekstrand et al., 2009:178; Poggenpoel & Myburgh, 2006:735; Badenhorst, 2005:102) aver that the fire of negative emotions experienced following the TOP is further fuelled by the following variables:

- Her beliefs, for example that “it is not a baby until it is born” (Steck, 2011:19), conflicting with her and others’ religious, moral, or ethical views and beliefs.
- Pre-existing emotional or psychological issues.
- Persuasion, coercion, or pressure by others to terminate the pregnancy.
- Lack of support from significant others.

The “sense of relief” experienced by some women as a result of their TOP and confirmed by several sources in the literature (whereby the TOP is perceived as a “quick fix” or solution to a problem which has the potential to derail her life, or seen as a way to keep/regain control or keep the UP a secret) (Kjelsvik & Gjengedal, 2011:174; Ekstrand et al., 2009:177; Fergusson et al., 2007:11) was not expressed by Participant D and E. In reflecting on their accounts of the feelings and emotional reactions experienced following their TOPs, I came to the realisation that the experience was traumatic for them and that it affected them physically and emotionally (Frederico et al., 2018:335; Steck, 2011:18), “because it involved a human death experience, specifically, the intentional destruction of one’s unborn child... as well as a violation of parental instinct and responsibility, the serving of maternal attachments to the unborn child and unacknowledged grief” (Major, Appelbaum, Beckman, Dutton, Russo & West, 2009:863).

4.3.3 Theme Three: Participants' accounts of the nature of the support received in relation to their UPs and/or TOPs, how they experienced this support, and how they would have liked to be supported otherwise

As is true for all individuals, TSs are confronted with diverse life challenges. An UP that may result in a TOP is one such challenge (Van Breda, 2011:iii). An UP is appraised as a very significant and pressing life challenge, responsible for the derailment of the academic aspirations of many a student. In spite of its devastating aftermath, various scholars note that students presenting with an UP and/or TOP rank the lowest in terms of help and support from family, friends, and/or counsellors (Ekstrand et al., 2009:176-177; Arhin & Cormier, 2008:213; Sekgobela, 2008:106; Naidoo et al., 2006:341). Van Breda (2011:1V), in a study focusing on social work students' experiences of life challenges, conducted research amongst 370 undergraduate social work students at the University of Johannesburg (South Africa) with the purpose of describing the nature and extent of the psychosocial vulnerability of these students, as well as the impact thereof of their psychosocial and academic functioning. He found that 80% of the student participants in his study who may have needed formal support from a counsellor "did not obtain it, and a third of those who did, obtained it off-campus" (Van Breda, 2011:iv).

Reaching out for help and receiving support when confronted with the reality of an UP and/or a TOP (if this route is opted for) is of paramount importance. Such support solicited or received, irrespective of whether it is professional by nature or informal support, will assist students in the decision-making process on how to manage the UP. It will assist them in deciding whether to continue with the pregnancy and raise the child; make the child available for adoption after they have given birth; or to terminate the pregnancy. Having a convoy of support available will make it possible for the student to continue with her studies and pursue her educational goals. Having support available and reaching out to this support could furthermore serve as a buffer to prevent a future UP and foster students' general psychosocial wellbeing and resilience (Kjelsvik & Gjengedal, 2011:173; Van Breda, 2011:7; Ekstrand et al., 2009:176; Sekgobela, 2008:36).

The theme on the participants' accounts of the nature of support received in relation to their UPs and/or TOPs, how they experienced this support, and how they would have liked to be supported otherwise is sub-divided into three sub-themes and seven categories. It was derived from the following request that I put to the participants during the interviews I had with them: *"Please tell me about the types of support that you received in relation to your UP and/or TOP, on campus and off campus."* In addition, I posed two follow-up questions. They were:

- Share with me how you experienced the support that you received.
- Looking back on the support that you have received, what would you have liked to be different in terms thereof?

When fitting the information that emerged from this request and the questions put to the participants, and the theme subsequently derived from it, into Schlossberg's Transition Process Model as the adopted theoretical framework for this study (Workman, 2015:5; Anderson et al., 2012:38; Schlossberg, 2011:160) it ties in with the aspect of *"Support"* in this model (Workman, 2015:5; Anderson et al., 2012:38; Schlossberg, 2011:160) (see Section 1.4).

Schlossberg (1981:10-11) avers that apart from individuals' own attitudes, abilities, and coping strategies, their ability to cope with events and transitions, as well as to adapt to them, is further strengthened or hindered by the interpersonal and institutional support to their avail and the physical settings they find themselves in. For this author, the physical setting relates to the living arrangements, location, and personal space of the individual (Schlossberg, 1981:12). Interpersonal support refers to support from the family unit, the network of friends, and/or intimate relationships (Grey, 2014:1198; Sereno et al., 2013:145-146; Schlossberg, 1981:10-11). Institutional support systems include occupational organisations, religious institutions, political groups, social welfare groups, and community support groups that one can approach for assistance and support (Schlossberg, 1981:11).

From the participants' responses it became clear that they enlisted professional and informal support, both on and off campus, for their UP and/or TOP transitions after the suspicion of the UP had been confirmed.

This information will be presented under the following sub-themes:

- Participants' accounts of the on- and off-campus professional and informal support sought and received.
- Participants' accounts of how they experienced the on and off-campus professional and informal support sought and received.
- Participants' accounts of what they would have liked to be different in terms of the on and off-campus professional and informal support sought and received.

4.3.3.1 Sub-theme 3.1: Participants' accounts of the on and off-campus professional and informal support sought and received

In the table below, an exposition is provided of the on and off-campus professional and informal support sought and received by the participants in relation to their UPs and/or TOPs.

Table 4.6: Excerpts from the transcribed interviews of the TSs to substantiate sub-theme 3.1

Source of support	Excerpts from participants
Professional support sought on campus	<p>“... it [referring to the satellite office of a CPCC that was established at one of the campuses of one of the participating tertiary institutions] is at the campus itself which is wonderful. They [referring to the volunteer counsellors at the CPCC] gave me a lot of options, looking at my circumstances...” [Participant A].</p> <p>“... I am... still seeing her [referring to a student counsellor] for counselling” [Participant C].</p> <p>“... the counselling – I went there [referring to the campus clinic] ...the sister there told me that I was pregnant... then she referred me to the counsellor [referring to a counsellor at the satellite office of a CPCC that was established at one of the campuses of one of the participating tertiary institutions] ...they take you in for counselling so that you can know what to do from there... at that time, ...I already had made up my mind I don't want to hear anything that... the counsellor was saying. So, it was just abortion in my head. But then, after the, after the abortion, I decided to go for counselling again because I really needed help, I needed someone to talk to. Then, as I started with... going for counselling...” [Participant E].</p> <p>“I went to the campus clinic... I saw counsellors here at school [a way of referring to the tertiary institution] ...she helped as well... and the nurse [at the campus clinic], as well...” [Participant F].</p>
Professional support sought off campus	<p>“Near Spar [a grocery store] there is a doctor [referring to a private doctor that she consulted off-campus] ...It's close to campus... So every time I'll go to the doctor... maybe if I have a little pain... you know the doctor</p>

	<p><i>will... see me... and he wouldn't take money [the doctor treated her free of charge] you see..." [Participant B].</i></p> <p><i>"Oh... I came here [referring to the CPCC situated in Pretoria/Tshwane] the first day [after finding out that she was pregnant] and I met a counsellor" [Participant D].</i></p> <p><i>"...okay it starts when I had to go to the doctor to go and check how far I am [referring to how far her pregnancy had progressed] ...and to book... for the abortion... Then, the following day, I had to go to the doctor... again, 'cause I thought maybe something is wrong... I had pain and bleeding... so then I had to call an ambulance... I had to stay in the hospital from Monday to Thursday..." [Participant E].</i></p> <p><i>"...off campus, I did see a doctor, but that was for the ultrasound..." [Participant F]</i></p>
Informal support received on campus	<p><i>"...and my friend [referring to her friend who is also a student and resides in the same residence], if I feel... sick, she cook for me. She's always there for me" [Participant C].</i></p> <p><i>"I had the support of my friends [referring to three friends who reside in the same residence with her] and then they, nobody pressured me to do anything I didn't wanna do. It was up to me... but my friends came, the ones that were there all the way, always just trying to make me feel better, just talking to me, just being with me all the time so that I just don't stress too much... going with me all the way to the doctor... I can, I will say they were... So they were always visiting me [referring to the four days that she was in hospital when she had her TOP] [Participant E].</i></p> <p><i>"...My friend [referring to a friend, also a student, on campus] was there all the way for me... And my lecturer as well" [Participant F].</i></p>
Informal support received off campus	<p><i>"...since I've told my mother, she always... every day she called me she asked if I'm okay... And my boyfriend, he also called me every day to ask if I'm okay" [Participant C].</i></p> <p><i>"...and my boyfriend has been... Oh my gosh! He's been like my foundation, or something – he's been supporting me all the way. And my mother..." [Participant F].</i></p>

From the storylines provided next to the category of “on-campus professional support sought” (in the Table above), it becomes clear that Participant A, C, E, and F utilised the on-campus *medical and/or counselling support services*.

On-campus health clinics and counselling services aim to provide a free, confidential, and professional support service, to all duly registered students, whether the reason for using such service is a medical, personal, and/or academic-related problem being experienced (Kaur, 2016:127; Van Breda, 2011:24; Martin & Oswin, 2010:59; Rosen, 2010:17, 349-350; Naidoo & Kasiram, 2006:346). In some instances, a nominal fee might be charged for the medical services offered, such as blood or pregnancy tests.

Participant B mentioned that she made use of the medical services of a private general practitioner off-campus. She indicated that his practice was close to her place of residence/campus and that it was convenient for her to utilise this service. This was the only source of support referred to/utilised by her.

Participant D indicated that she made an appointment to see a counsellor at the offices of the participating CPCC situated in Pretoria (Tshwane) (background information regarding this CPCC was provided in Section 1.2) once her UP was confirmed.

Participant E and F disclosed that, aside from making use of the professional support services offered on-campus, namely the campus health professionals and counselling support services, they also utilised medical support off campus.

The reason for students suspecting an UP and afterwards seeking off-campus medical support is due to the fact that on-campus health services/clinics generally do not offer specialised medical treatment and procedures. Speaking from the South African-context, if a student is pregnant and needs or wishes to have an ultrasound scan, she will have to use either private or public health services available and the on-campus healthcare practitioner can make a referral in this regard (Ricks, Strümpher & Van Rooyen, 2010).

Participant C, E, and F who, at the time of the confirmation of their UPs, stayed in accommodation provided by the university (see Table 4.3), mentioned that their friends formed part of their on and off-campus convoy of support. They also accessed professional on-campus support (seeing a counsellor and nurse respectively). In addition, Participant C and F also made reference to their mothers and boyfriends as their pillars of strength and support. Participant F was the only one who mentioned approaching a lecturer for support. On this aspect of approaching lecturers for support when in this quagmire of an UP, Van Breda (2011:iv) notes that “lecturers and tutors are reported to be helpful and supportive and most likely to refer students for counselling.”

The crisis of an UP and/or TOP remains a private issue for many young women due to the fear of being stigmatised, judged or rejected; being coerced into a decision that is not authentically their own; or because of other's lack of understanding and support. This often results in the UP and/or TOP being kept a secret. When they eventually decide to make a disclosure and reach out for help, they tend to be very calculated and selective in terms of whom to disclose to and involve in this matter (Rahman, Rahim & Arif, 2017:70; Kjelsvik & Gjengedal, 2011:172; Ekstrand et al., 2009:173; Arhin & Cormier, 2008:213; Naidoo & Kasiram, 2006:346).

To refrain from reaching out for professional support when confronted with the reality of an UP and/or a TOP is a source of great concern (Van Breda, 2011:24) and causes severe stress (Naidoo & Kasiram, 2006:348). Being aware of resources available to provide professional support and utilising such support services, as well as having informal support available, is pivotal to mitigate the challenges associated with an UP or a TOP (Steck, 2011:42; Arhin & Cormier, 2008:213, 216).

4.3.3.2 Sub-theme 3.2: Participants' accounts of how they experienced the on- and off-campus professional and informal support sought and received

The participants, in reflecting on how they experienced the on and off-campus professional support sought and the informal support received, relayed both positive and negative experiences. This led to this sub-theme being divided into two categories, which will be presented next, starting with the positive experiences and thereafter the negative experiences.

a) Category 3.2.1: Positive experiences related to the on- and off-campus professional and informal support sought and received

The storylines below testify to the positive experiences of all six the TS-participants in relation to the on and off-campus professional and informal support sought and received.

Participant A felt positive about the counselling services that she received. She stated: *"The counsellor [referring to the volunteer counsellor from the CPCC] ...what's nice about that... you don't have to pay anything... the service that I was getting was, it was impeccable..."* Later in the interview she also reminisced about the support from her family. She remarked: *"...they were a big part of my life then and it still is today... the support is definitely there... family support is very important..."*

Participant B remarked on the value of the support from her friends: *"...my friends... they were... on my side, they said, 'Ah, you are not the first person to become pregnant, at least you are 19... some are getting pregnant on [13] ...and some... when they are 19 it's their second child'... so they were saying such things... They were supporting me..."* She continued: *"Firstly, my friends, 'cause like I didn't want to attend... classes. So my friend will come to my room, knock... 'Let's go to class'. Every morning she was doing that... Then, if maybe we have a class activity, she will come... 'Have you done that?' – 'No, no, no I'm still busy with it...' So we had an assignment... last week, they decided to do [it]... It was supposed to be the group of three. I expected them to come and fetch me so that we will go to the Internet. But they didn't call me. When I came across them they were having this assignment – 'Hau! Have you finished the assignment?' 'Yes.' And I, they typed my name on it. I said, 'Hayibo people, why didn't you ask me to come?' 'Ah, don't worry'."* She also made reference to how her mother and grandmother supported her: *"...my mum would call me each and every day, asking, 'Are you fine?' In the morning, then maybe my grandmother."*

Participant C spoke about her friend's support along the following lines: *"... and my friend, if I feel sick, she cooks for me. She is always there for me..."*

Participant D relayed her positive experience about the counselling support that she received as follows: *"So I had support afterwards and I came here [referring to a CPCC] like, as soon as I came to Pretoria. First of all, the environment is welcoming [referring to the counselling environment of the CPCC] ...I don't know how to answer you, but I can say that, whatever they're doing, they're doing it right"*

because today I feel better than in January. So, whatever they're doing, they're doing it correctly. [Laugh] The support that they're giving is correct."

Participant E reflected on the counselling support she received from a volunteer counsellor at the satellite office of a CPCC that was established on one of the campuses of one of the participating tertiary institutions and how helpful it was. She shared her experience as follows: *"Extremely helpful [referring to the counselling that she received] 'cause I was losing my mind... it [referring to the counselling] really helps you just to take out all your feelings... I go every week. They [referring to the staff at the CPCC] have a journey [referring to the counselling programme offered by the CPCC] that you need to go through. There are a lot of... stages. Then we just discuss... the feelings that we feel about the abortion, everything that just surrounds us concerning the abortion as well, so that we can deal with the trauma from the abortion... after just going through that, I just realised that it really helps."*

Participant F spoke about how comforting the support was that she received from a healthcare professional and student counsellor on her campus, as well as the support from a friend on campus, her boyfriend and her mother: *"...it was very overwhelming and great to know that I'm not alone in this – there are actually people who are behind me all the way. And it's... it's great just to know that you are not alone."*

The positive appraisal of both the on and off-campus professional and informal support sought and received is greatly beneficial to the student who has to deal with an UP and/or a TOP. Van Breda (2011:8) posits that such support has a positive impact on the student's academic performance by minimising the negative effect brought about by UP and the academic stress and vulnerability added by it. An UP and the decision taken about its outcome impacts on the student's grades, study methods, access to academic resources, and class attendance and can be regarded as a life experience in the student's social environment that impinges on her personal or psychosocial development and/or wellbeing (Van Breda, 2011:2)

Friends and family who are readily available, providing a listening ear and offering practical support, fuel the determination of the student to cope with this life challenge experienced (Rocca, Kimport, Gould & Foster, 2013:126; Kjelsvik & Gjengedal, 2011:172; Van Breda, 2011:21; Wilks & Spivey, 2010:278; Martin & Oswin, 2010:58; Wilks, 2008:120). In addition, maternal support has been noted as instrumental in the decision-making process of how to deal with and cope with an UP (Rocca et al., 2013:126; Arhin & Cormier, 2008:214).

Although concerns are noted about the aspects of confidentiality and anonymity with reference to the utilisation of formal on-campus health and/or counselling services, students who accessed such services perceived and described the information and support received as “beneficial and helpful” (Van Breda, 2011:8; Aujoulat et al., 2010:451; Ekstrand et al., 2009:176-178; Badenhorst, 2005:102).

b) Category 3.2.2: Negative experiences related to the on and off-campus professional and informal support sought and received

While Participant D appraised her contact with and support received from the volunteer counsellor at the CPCC (situated off-campus, in Pretoria/Tshwane) as positive, she experienced the lack of support from her mother and grandmother, as well as the unfavourable view that they took about her UP, as quite negative. She shared the following in this regard: *“Nothing [no support]. I was alone... ‘cause it was just the three of us [referring to herself, her mother, and her grandmother] ...deciding [to terminate the pregnancy] and no-one’s gonna know... I felt really bad, I didn’t even eat. I just stayed in my room and I had no support from them. I lost a lot of weight and my mum was busy complimenting me saying that I look nice and she couldn’t see that maybe it came from me not being happy, me... just being depressed.”*

The pressure exerted on Participant D to terminate her pregnancy (elaborated upon earlier in this chapter (see Section 4.3.2.2) resulted in her experiencing an array of feelings such as loneliness, isolation, anger, and depression (see Section 4.3.2.3).

To keep the UP a secret, as Participant D did initially, is not an uncommon occurrence (Grey, 2015:737; Van Breda, 2011:20; Ekstrand et al., 2009:176). Such a decision, together with the lack of reaching out for formal and professional support, results in the UP-transition being a lonely journey characterised by feelings of fear, anxiety, anger, resentment, and depression (Grey, 2015:737-738; Van Breda, 2011:24; Ekstrand et al., 2009:176). This is reflected in Participant D's utterances that she, after disclosing her UP to her mother and grandmother and prior to the decision forced on her to terminate her pregnancy, felt that she "was alone" and "had no support from them". Because this made her feel like she was losing her mind, she went for post-abortion counselling after her TOP which she found to be "extremely helpful".

In spite of the negative post-abortion counselling experiences reported in the literature consulted, such as nursing staff being unsympathetic, accusing patients of promiscuity or irresponsible sexual behaviour, and stating that the UP and/or TOP is a form of punishment for the sins they committed (Grey, 2015:738; Ekstrand et al., 2009:177-178; Ratlabala et al., 2007:30), the positive experiences reported far outweigh the negative experiences. Post-abortion counselling seems to reduce distress and depression. Women attending this type of counselling acquire self-knowledge; knowledge about this life-changing experience; and how to grieve the losses incurred in order to come to a stage of acceptance of the decision taken regarding the TOP. The counselling experience leaves them more independent, mature, and responsible (Kjelsvik & Gjengedal, 2011:173; Van Breda, 2011:21; Ekstrand et al., 2009:178; Poggenpoel & Myburgh, 2006:739; Badenhorst, 2005:102; Mpshe et al., 2002:79).

In addition to my request to the TS-participants to reflect on their experience of the support that they received, I also asked them to look back on the support that they received and share their views on what they would have liked or wanted to be different in terms thereof. Their responses in this regard are presented as categories to the sub-theme below.

4.3.3.3 *Sub-theme 3.3: Participants' accounts of what they would have liked to be different in terms of the on- and off-campus professional and informal support sought and received*

The responses from the participants to the question *“Looking back on the support that you have received, what would you have liked to be different in terms thereof?”* are clustered under various categories and presented next.

- a) Category 3.3.1: A participant would have liked to have more information about the on- and off-campus support services available to her

The reflection shared by Participant B's gave rise to this category: *“I think they [referring to those offering support services] have to make us aware because we as the student... we just staying inside the premises but we, we knew nothing about that [referring to the availability of support services on and off campus]”* [Participant B].

Several scholars underscore the fact that being comprehensively and accurately informed about the options available to deal with an UP, as well as being knowledgeable about the resources and support services from where such information could be obtained, will assist in the process of making informed decisions about how to deal with the UP. Lacking both information and support in this regard can place the student presenting with an UP at a serious disadvantage and increase her vulnerability (Grey, 2014:1196, 1198; Rosen, 2010:17-18; Wilks & Spivey, 2010:277; Ekstrand et al., 2009:178; Arhin & Cormier, 2008:214; Ratlabala et al., 2007:30; Badenhorst, 2005:101).

Participant B's confession about being ignorant and ill-informed about the on and off-campus support services available to students with UPs contradicts the notion of some scholars that university students, in general, have sufficient knowledge about issues such as contraception, sexual health, relationships, and other psychosocial problems, as well as resources available to support and assist them in this regard (Coetzee & Ngunyulu, 2015:3; Adams & Williams, 2011:1876, 1881;

Ekstrand et al., 2009:176; Abiodun & Balogun, 2009:146; Sekgobela, 2008:3; Ratlabala et al., 2007:30).

Several scholars on the other hand confirm Participant B's admittance to the lack of information about the on and off-campus support services available to TSs confronted with UPs and/or TOPs (Tabane & Mmapheko, 2015:4; Miller, 2011; Badenhorst, 2005:97-98). Such ignorance is alarming in view of the fact that learners, during life orientation programmes at school, as well as during orientation programmes and awareness campaigns presented to students at tertiary level, are informed about the topics of reproductive health, safe sex practices, UPs, and TOPs, as well as the services available attending to these matters, both on and off campus (Coetzee & Ngunyulu, 2015:3; Rosen, 2010:18; Miller, 2011:69).

The manner in which the on-campus resources and support services available to students confronted with personal and/or academic-related crises are marketed, and the prevailing stigma attached to some of these services and the students utilising them are reasons cited for students not being aware of such resources and not willing to utilise them (De Lange & Geldenhuys, 2001:254). It is for this reason that Van Breda (2011:25) calls for a critical review of how support services are brought to students' attention. In targeting students with an UP, he suggests an active marketing strategy in which the range of resources and services available are publicised in a destigmatised and positive fashion. In addition, he advocates for educational endeavours to student populations at large to decrease the stigmatisation attached to such services and the users thereof.

- b) Category 3.3.2: Participants would have liked to have more support from their significant others

Participant C, D, and E were the ones indicating that they would have liked to have more contact with and support from their significant others. The narratives below illustrate this.

Participant C said: *"...if only I was... with my mother, every day and if I feel something, to talk to her."*

Participant D stated it as follows: *“...because they [referring to her mother and grandmother] didn’t support me at all, even after... the abortion thing... I came to school and that was it... Had they backed me up, I would have... kept the baby. I wouldn’t have had an abortion, had I gotten the support that I should have gotten from them...”*

Participant E relayed: *“...he [referring to her boyfriend] wanted me to keep the baby and I gave him my reasons why I couldn’t. So, then things changed from there and he... just didn’t support me through the abortion... I would have liked my boyfriend to also support me through the whole situation.”* She later on in the interview also admitted that, if her parents knew, they could have assisted. She spoke about this as follows: *“... maybe for my parents to know... then... they help [sic] me if I’m feeling down or not doing well then they can just support me, but then, I just can’t tell them...”*

Partners or parents sometimes react with anger, panic, indifference, or rejection when being informed about a confirmed UP (Lanre, 2010:198). This is even more likely when the relationship with the child or girlfriend is strained and characterised by a lack of trust and poor communication. Significant others also underestimate the impact of their initial response and the influence their covert or overt lack of support has on the pregnant child or girlfriend and how she manages the whole affair (Didaba, Fantahun & Hindin, 2013:136; Ekstrand et al., 2009:178; De Lange & Geldenhuys, 2001:252). An unintentional or deliberate lack of understanding of her thoughts, feelings, and vulnerability, as well as a lack of support, will give birth to feelings of disappointment, despair, isolation, sadness, loss or anger, or intensify such feelings if they are already present (Didaba et al., 2013:136; Kjelsvik & Gjengedal, 2011:173; Poggenpoel & Myburgh, 2006:736; Badenhorst, 2005:93-94; Mpshe et al., 2002:74).

In confirming the need for understanding and support from significant others, which Participant C, D, and E mentioned they would have liked, the literature consulted emphasises the importance of such support, especially when it comes to deciding on how to manage the UP. They want the significant others to provide nuanced advice and do it in a calm and collected fashion (Adams & Williams,

2011:1880, 1881; Kjelsvik & Gjengedal, 2011:174; Ekstrand et al., 2009:176). Where the significant others are prescriptive in the advice given or threatening to withdraw their support in an attempt to enforce their will on the child or a partner, as Participant D's mother and grandmother did, it can result in the decision executed later being regretted. The nature of the support being provided by significant others will help to ease the psychosocial pain and stress accompanying this life transition and will strengthen the relationships with significant others (Van Breda, 2011:6, 24). On this point of strengthening relationships and growing as individuals, couples and families, Moos and Tsu (in Schlossberg 1981:6) state: "a transition may provide an opportunity for psychological growth or a danger of psychological deterioration."

- c) Category 3.3.3: Participants would have liked to have more information about the different options available when dealing with an UP

The utterances made by Participant D and E gave rise to this category.

Participant D reminisced as follows: *"And I just wish I'd had someone who would've told me the truth... 'yeah girl, it's gonna be bad, it's gonna scar you' [referring to the TOP-procedure affecting her in a negative way] ...especially if you wanted to keep the baby..."*

Participant E stated: *"I just wish I knew more... what to do [referring to her need for information about the UP-options]."*

The lack of information about the different options to choose from when dealing with an UP, as admitted to by Participant D and E, is not surprising. Several scholars (French, Steinauer & Kimport, 2017:716; Hornberger, 2017:2; Tabane & Mmapheko, 2015:2; Ratlabala et al., 2007:29; Badenhorst, 2005:97) point to this, mentioning that insufficient and incorrect information on the options available to deal with an UP abounds, with such information being premised on myths and/or traditional/cultural, religious or moral beliefs leading to courses of action to be taken which, later in life, are regretted. It seems that sexual health education mainly focuses on prevention in terms of abstinence education, as well as

measures to prevent pregnancy and/or STIs, with very little or no emphasis on the guidelines, options, support, or interventions available, should a challenge such as an UP or STI occur (Hornberger, 2017:2; Adams & Williams, 2011:1881).

Rosen (2010:17-18), in her study conducted at a university in Texas, USA, amongst students enrolled in university seminar courses about the attitudes, perceptions, and experiences of college students regarding sexual health issues, emphasises that the aims of sexual health education in tertiary settings are to “offer information, to enable students to become comfortable with discussing sexual health and to facilitate good decision-making skills”, with the aspect of the promotion of abstinence prominently reflected in the syllabus. The research, however, found that the sex education materials in the syllabus of the mentioned courses at this university often include factual errors and distortions about contraception and STIs, and that virtually no information is provided regarding the different options when confronted with an unintended pregnancy or STI (Rosen, 2010:18).

Adams and Williams (2011:1881) confirm that not nearly enough information exists or is available to students on the topic of options to choose from when confronted with an UP with reference to parenting, TOP, and the various forms of adoptions (Kjelsvik & Gjengedal, 2011:174; Ekstrand et al., 2009:178).

- d) Category 3.3.4: Participants would have liked to be better prepared for the TOP-process and procedure

Participant D and E, who opted for TOP, indicated that they would have liked to be better prepared for the TOP-process and procedure.

Participant D disclosed the following: *“I wish that I had, I had someone who would’ve told me... exactly what you’re gonna go through after you have an abortion... we have this perception that you solve the problem, it goes away, you move on with your life and, you know what, emotional scars are very hard to heal than physical scars and that’s what people don’t know.”*

“I didn’t know what was going to happen afterwards [referring to after the TOP-procedure] ...I just thought it was just gonna be easy but then, abortion doesn’t make it easy” [Participant E].

This category and Participant D and E’s utterances tie in with the previous category presented. It underscores the sentiments noted in the literature consulted that TSs presenting with an UP need to be adequately informed about the options available to choose from when dealing with an UP. With regard to TOP, they need to be comprehensively informed about the TOP-procedure, the invasiveness thereof, and the physical and/or emotional distress and trauma resulting from it, as well as the convoy of medical, emotional, and practical support needed and required in this transition (French et al., 2017:217; Hornberger, 2017:3; Kjelsvik & Gjengedal, 2011:174; Miller, 2011:69; Steck, 2011:18-19; Ekstrand et al., 2009:173; Mpshe et al., 2002:77).

Entertaining the perception, as both Participant D and E did, that the termination of a pregnancy is a “quick fix” to an UP promotes unrealistic expectations leaving many young women unprepared for the realities that they eventually have to face (French et al., 2017:216; Hornberger, 2017:2-3; Ekstrand et al., 2009:177; Arhin & Cormier, 2008:212-213; Poggenpoel & Myburgh, 2006:739; Mpshe et al., 2002:79).

Post-abortion reflections indicate that the termination of an UP is generally perceived to be “much worse” than imagined or expected (Coleman, Boswell, Etzkorn & Turnwald, 2017:116). Various scholars confirm that the initial sense of relief experienced after the TOP, especially in terms of the ability to continue with one’s studies, relationships and social life, is overshadowed by an overwhelming sense of adversity and negativity (Coleman et al., 2017:116; Van Breda, 2011:24; Ekstrand et al., 2009:177; Poggenpoel & Myburgh, 2006:734; Badenhorst, 2005:101).

- e) Category 3.3.5: A participant would have liked to be less afraid of what she believed others were thinking or saying about the ordeal of her UP

Participant F shared the following, which gave rise to this category: *“...If I could tell more people, and if I wouldn’t be so afraid of what they might be thinking and the things they might be saying...”*

The perception of the young woman in the quagmire of an UP about what others may say and think about her, as in the case of Participant F’s account, is not only influenced by her own moral, religious, cultural, or traditional values and beliefs, but also by those of others in her social world and context. This has been found to have a direct influence on whether the UP will be disclosed or not, as well as the outcome of the decision taken on how to deal with the UP and whether it will be made public or kept a secret (Smith, Turan, White, Stringer, Helova, Simpson & Cockrill, 2016:76; Badenhorst, 2005:97).

This then concludes the presentation of the research findings related to the theme on the participants’ accounts of the nature of support received in relation to their UPs and/or TOPs, how they experienced this support, and how they would have liked to be supported otherwise. In the next section, the last theme that emerged from the data collected from the TSs will be presented. This relates to their suggestions for psychosocial support to students presenting with an UP and/or TOP, based on the participants’ experiences and support received.

4.3.4 Theme Four: Suggestions for psychosocial support to TSs presenting with an UP and/or TOP

This theme emerged from the responses obtained from the following question put to the participants: *“Based on your experience as a TS who had an UP and/or a TOP, what suggestion(s) do you have on how students who present with an UP and/or TOP could/should be supported?”*

The suggestions forwarded by them speak to the aspects of *“Support”* and *“Strategies”* in Schlossberg’s Transition Process Model (Workman, 2015:5;

Anderson et al., 2012:38; Schlossberg, 2011:160) as the adopted theoretical framework for this study. For an explanation of what Schlossberg means under this aspect of support, the reader is advised to revisit Section 1.4.

Strategies in the context of Schlossberg's Transition Process Model (Section 1.4) point to ways and plans to manage the transition offset by the UP and/or the TOP, and to progress towards adaptation to transition. Schlossberg also advocates for the use of an array of (coping) strategies, as it results in improved management of the transition (Workman, 2015:5; Schlossberg (2011:161).

The suggestions offered by the TS-participants, based on their own experiences and the support received, or lack thereof, resulted in one sub-theme to be presented next.

4.3.4.1 Sub-theme 4.1: Participants' suggestions for medical and counselling support, peer support and education, awareness campaigns, as well as academic-related support to students with UPs and/or TOPs and suggestions to students to utilise this support

As the participants made suggestions related to the facets of medical, counselling, and academic-related support to be offered with students with UPs and/or TOPs, as well as suggestions to utilise this support, the suggestions forwarded will be presented under the following categories:

- Suggestions for medical support offered to students presenting with an UP and/or a TOP.
- Suggestions related to counselling support, peer-support and education, and awareness campaigns for students presenting with an UP and/or a TOP.
- Suggestions for academic-related support to students presenting with an UP and/or a TOP.

- a) Category 4.1.1: Suggestions for medical support offered to students presenting with an UP and/or TOP

The suggestions for medical support offered to students confronted with an UP and/or a TOP made by the participants are shared below.

Participant A made a **suggestion regarding the accessibility of the on-campus health clinic**, when stating: “...*maybe just being able to pop into the campus clinic and getting your... just getting your pre-natal vitamins, maybe just check your blood pressure...*”

Participant B’s **suggestion was for a place on-campus where students who experience an UP and/or TOP-related emergency can be taken to**, or for on-campus medical personnel coming to the student. She proposed: “*I think they [referring to on-campus medical staff] must organise something for us even in the medical [referring to the clinic or the on-campus medical facility], if you get sick when you are within the school premises [at the university], I think you, you’ll be in a safer site when we have medical [emergency]... ‘cause if you have something they can rush to... you within the premises.*”

Participant E recommends that “...*some medical help... check-ups...*” be offered on-campus to students who are pregnant.

Participant F **proposed the availability of on-campus doctors that students can go to for** “...*just a simple check-up; not complicated – just a simple check-up*”. This suggestion was made for the fact that “*The school [referring to the University] clinic doesn’t offer help to pregnant [students] ...they just transfer you to other clinics.*” With reference to accessing the community clinic, she stated: “...*this thing of always going to the clinic and waiting there [is frustrating], as sometimes your day’s too busy, or sometimes there’s like just a very long queue at the clinic.*”

Participant F’s suggestion corresponds with the view held by several scholars pointing out that TSs in particular, “are not keen” on visiting/utilising the health

resources, such as community health clinics (Bafana, 2010:10). Inaccessibility in terms of location and the distance from the tertiary institution, as well as other practical considerations such as the lack of transport money to get to the clinic, its operating hours, and the waiting time to be attended to, were noted as barriers for students to utilise these resources (Bafana, 2010:10; Rosen, 2010:12; Patel & Kooverjee, 2009:551).

Where medical resources are accessible, women are encouraged to seek out the appropriate health service they need (Baird & Porter, 2011:154; Burgen, 2010:23; Levi et al., 2009:301).

Apart from the suggestions forwarded by the participants about the on-campus pregnancy-focused services being available to students, Participant D, also by way of implication, **suggested that on-campus medical staff should be more service-orientated and patient-friendly** after appraising the nursing staff as being unfriendly. She referred to the perception and insinuation of some healthcare practitioners that the occurrence of an UP is the result of ignorance and carelessness amongst the students and remarked: *“They tell you that you’re busy falling pregnant when you’re young, I mean, can’t you think...Nurses are not the friendliest people on earth. They’re not friendly at all.”*

Participant F critiqued nurses, including healthcare practitioners on campus and nurses at the community clinics, for not taking students seriously when they complain about oral contraceptives having definite negative side-effects on them and proposed a suggestion in this regard when stating: *“...like nurses don’t take it seriously when we tell them that... pills have an effect on us. They really do not take it seriously, they think we’re crazy, or something... there should be some prevention method that they know is safer that they can just tell students to just take.”*

Women facing an unintended pregnancy may feel shocked, scared, overwhelmed, and vulnerable by the state of affairs (Steck, 2011:31) and those who have undergone a TOP view it as a violent and disempowering experience (Aujoulat et al., 2010:449). For these reasons various scholars advocate for an understanding

to be displayed by healthcare professionals and for them to react with sensitivity and understanding to the concerns of patients presenting with UPs and/or TOPs (French et al., 2017:716; Kjelsvik & Gjengedal, 2011:173; Aujoulat et al., 2010:451; Ekstrand et al., 2009:177-178).

Support for Participant D and F's negative appraisal and critique of nursing staff was found in the literature consulted, with several scholars (Rahman et al., 2017:70; Bafana, 2010:10; Rosen, 2010:19) reporting on the unfriendly, rude, and unapproachable attitude displayed by healthcare professionals. Some of them even judged TSs for presenting with an UP and/or their decision to terminate the pregnancy. Even more alarming is the overt pressure executed to convince students not to follow-through with the decision to terminate the pregnancy.

It is acknowledged that patients with UPs and/or those requesting a TOP may present a conundrum to some healthcare professionals' own belief systems. In such cases, healthcare professionals, especially those who do not provide specific services related to an UP and/or TOP because of their personal, moral, or religious beliefs, are advised by Levi et al. (2009:310) to provide their patients with a "timely referral to another health professional known to provide such services".

Participant E had the following suggestion for students: *"...use the clinic... more for preventing, for what you call this – Family Planning."*

On the topic of using clinics for family planning, as suggested by Participant E, Tabane and Mmapheko, (2015:4) postulate that, in South Africa, government hospitals and community clinics are the major family planning and contraceptive SPs offering such services free of charge (Bafana, 2010:10).

With this said, difficulties in finding suitable contraceptives in terms of a choice in the variety of contraceptives available in the public health sector; worries about contraceptives' side-effects; compliance challenges; and difficulty in accessing family planning services have been cited as SP and patient barriers to contraceptive use (Tabane & Mmapheko, 2015:4; Bafana, 2010:10; Ekstrand et al., 2009:176).

Linked to the suggestions for medical support was a **suggestion for financial support** to meet the medical expenses of a pregnant woman and her nutritional needs during pregnancy. This was not only the felt need of Participant C, but of all other students in the same boat. She expressed this need and a suggestion for financial support as follows: *“And the medical... eish, it is too much, the expenses... I don’t have anyone who can help me with that... Financial support is a need, yes... a need! You know... if, as I’m pregnant, I need to eat healthy food... Some of us we don’t have that money... Some of us, we... don’t have... those people [who] could give... us... the money to buy... healthy food. So, I think we need, need to have some healthy food”* [Participant C].

An UP has serious financial implications, not only for students, with some coming from poverty-stricken communities, but also for their families, the tertiary institutions, and ultimately also the government (Aiken, Dillaway & Mevs-Korff, 2015:150; Van Breda, 2011:3; Naidoo & Kasiram, 2006:341). While many students already struggle to survive financially and are anxious about their financial situations, an UP adds to and compounds this financial vulnerability already experienced (Aiken et al., 2015:149-150; Van Breda, 2011:3, 5; Martin & Oswin, 2010:52; Wilks & Spivey, 2010:281).

The suggestion for financial support informed by Participant C’s needs (as well as those of others she made reference to) is supported by the view of Adams and Williams (2011:1884) who state that financial vulnerability is a barrier, specifically in terms of the decision-making process regarding the UP.

The focus of the discussion now turns to the suggestions related to counselling support, peer-support, and education, and awareness campaigns for students presenting with an UP and/or a TOP, as forwarded by some of the participants.

- b) Category 4.1.2: Suggestions related to counselling support, peer-support and education, and awareness campaigns for students presenting with an UP and/or a TOP

The need for crisis pregnancy counselling and pre and/or post-abortion counselling are emphasised by several authors (Kilander, Bertero, Thor, Brynhildsen & Alehagen, 2018:104; Aujoulat et al., 2010:451). Others have reported on the positive outcomes of such person-centred support and counselling offerings to young women confronted with an UP-crisis, as well as the ones who have decided to terminate the pregnancy and are dealing with its aftermath (Stewart, McCall, McPherson, Towers, Lloyd, Fletcher & Bhattacharya, 2016:62-63; Martin & Oswin, 2010:58; Wilks & Spivey, 2010:279; Levi et al., 2009:308). Attending counselling sessions facilitated by social workers, psychologists, trained volunteer pregnancy counsellors, or healthcare professionals have been found to enable them to effectively manage the medical and psychological aspects and challenges related to the UP and/or the TOP (Burgen, 2010:24; Van Breda, 2011:6). Counselling provides them with an opportunity –

- to share the feelings they experience and their concerns related to the UP and/or the TOP, and in so doing lessening the psychological vulnerability associated with this life challenge.
- to ask questions about the options available to deal with the UP, and disclose their choice and course of action in this regard;
- to explore ways of physical and emotional self-care during the pregnancy and getting some pointers in this regard;
- to be assisted in terms of the post-abortion stress or trauma as a result of their TOP; and
- to obtain advice on how to deal with the relationship tension emanating from the UP.

With reference to the provision of pre and post-abortion counselling, the aims deduced from the literature consulted (Kilander et al., 2018:105; Kjelsvik & Gjengedal, 2011:175; Van Breda, 2011:26; Aujoulat et al., 2010:458; Burgen, 2010:25; Ekstrand et al., 2009:178) are as follows:

- The provision of accurate and easy-to-understand information on the TOP-procedure, its possible consequences, and how to prevent further unintended pregnancies.
- To tune into the young woman's thoughts, feelings, and vulnerability without casting any judgement or exerting any pressure.
- Assessing the signs of possible post-abortion stress and trauma and the management or lack thereof.
- Appropriate referral if necessary – in the case of postpartum depression for medical intervention.

Against the introductory remarks made to this category, also serving as confirmation, I will now present the participants' suggestions offered that gave rise to this category.

Participant D **suggested** that **counselling services** should be available country-wide where teenagers who become pregnant can go before making a decision on how to manage the UP. She forwarded the suggestion along the following lines: *"You know, so we need, we need services like this, across the country, in every province where teenagers can go to and they can be sort of given a bit of counselling before they take on the decision of whether to... abort, keep their child, adoption, and all of those things."*

Participant E, who herself opted for a TOP, **suggested post-abortion counselling**: *"I can just say, they [referring to students who choose to terminate their pregnancies] need to utilise the services here at school [referring to the University] so that it doesn't affect... their education, 'cause something like this [referring to the TOP] it's too [very] traumatic, it can really affect you in a lot of ways."* She also **suggested partner counselling** (for the young woman and the boyfriend who impregnated her), especially in the case of a TOP, to get his support and deal with the trauma related to this. She explained and suggested: *"...like you and your boyfriend need to... agree on the whole abortion thing, 'cause otherwise you won't get the support from the boyfriend since it's between you two. So it's... difficult for you to deal with it on your own... So ... both of you need... will need... counselling... since it will help you deal with the trauma..."*

Participant E's comment that it is *"difficult for you to deal with it on your own"* corresponds to similar accounts made by participants in other studies. In Ekstrand et al.'s (2009:173-180) study, which explored the perspectives on abortion decision-making among teenage women in Sweden, one of the participants stated: "I don't want to be pregnant on my own." In a Scandinavian-study by Kjelsvik and Gjengedal (2011:172-173) about the experiences of women who were pregnant for the first time regarding the decision-making process related to completing or terminating the pregnancy, one of their participants admitted that "It was terrible being left all alone to make the decision and take the responsibility".

Involving the partner of the young woman dealing with an UP and/or TOP, as recommended by various scholars (Stewart et al., 2016:62; Adams & Williams, 2011:1880; Ekstrand et al., 2009:178), is imperative, especially during the decision-making process to determine the outcome of an UP. A partner's involvement assists with reducing the feelings of isolation, disappointment, and despair experienced. Having him as part of the convoy of support (Kahn, 1975, in Schlossberg, 1981:10) will aid in the transition to adjust to the outcome of the UP.

Participant A not only **suggested telephone crisis counselling and on-going counselling**, but also **recommended what should be focused on during such counselling**. She presented the suggestions along the following way: *"Telephone crisis counselling... is a contact support structure and what I mean... being able to phone somebody and say, 'Listen, I'm pregnant' and that person knowing how to deal with it as a crucial and crisis management..."* She continued by suggesting: *"...on-going counselling... through your whole pregnancy... In the counselling, I would... say... empowering the student... with mechanisms to up their lifestyle in terms of... looking at the financial implications of having a baby. 'Now what do you do about it? Are you going to get a job? Maybe a weekend job when you're not studying... basically', Like I say, looking at how to up your lifestyle because... there is no ways that you can stay on a lifestyle as a student and have a baby... Looking at... what it means to be a parent in terms of the emotional side of it... 'you're going to be drained, you're going to feel... there's going to be evenings that you just want to just run away'. I mean I have absolutely empathy with mothers that, single mothers, that didn't have the support structure, that couldn't handle it,*

that ended up killing their babies because they didn't have anybody to say, 'Listen, I can see you're tired today, so I'm going to take your baby and you can relax, sleep'. Luckily, I had that... now my friend was there, but informing girls that this is going to happen... and maybe still being able to phone... someone... 'Listen, I'm feeling like this, what should I do?'. ”

Participant A's suggestion for telephone crisis counselling finds support in the literature consulted, with various scholars (Smith, Ly, Uk, Warnock & Free, 2017:82; Corkin, 2011:6; Burgen, 2010:28; Brosh, Weigel & Evens, 2009:4) highlighting the following advantages of both telephone counselling and online counselling:

- These types or modes of counselling are easy to access, anonymous, and immediately available, with the aspect of anonymity being preferred by students who fear stigmatisation and judgement, and who want to keep the UP and/or TOP a secret (as aspects already referred to in this Chapter – see Category 3.2.2).
- Telephone and/or online-counselling removes the barriers mentioned earlier in this chapter to the non-utilisation of community health clinics (see Section 4.3.4 – Category 4.1.1; Bafana, 2010:10; Rosen, 2010:12), with practical and/or emotional support, advice, and information being immediately available.

The need for ongoing counselling, expressed by Participant A, is underscored and recommended by Burgen (2010:21). Apart from crisis pregnancy counselling, as well as pre and post-abortion counselling, support and counselling on the topics of single parenting and parenting support programmes are suggested (Van Breda, 2011:24; Aujoulat et al., 2010:451-452; Burgen, 2010:30).

Participant F **suggested the idea of a peer-support group for students dealing with an UP** along the following lines: *“I feel if there were like groups where only pregnant students... met and just spoke about this... If it's a pregnant student and a pregnant student they can be able to just talk this over, and – ‘okay, this is what I'm going through’ and you'll know that you're really not alone...”*

While the value of formal support groups facilitated by health and social welfare professionals has been mentioned by several authors (Baird & Porter, 2011:153; Rosen, 2010:14), Bury, Hoggart and Newton (2015) are of the view that peer support groups are more helpful in dealing with the difficulties and challenges commonly shared. For Corkin (2011:3) and Brosh, Weigel and Evans (2007:4) the support offered to each other in an informal group is the best types of support on offer when dealing with an UP and/or TOP.

In Corkin's (2011:1-6) study focusing on students' perceptions of the support services provided by the Teen Pregnancy and Parenting Program in 2010-2011 at the Houston Independent School District, one of the participants of this study reflected on the value of and impact that her peer-support group had on her, when stating: "They helped me to find health services and community organisations providing further help... they helped me to take care of my health while I was pregnant and they motivated me to finish my studies..."

One of the adolescent mothers in Aujoulat et al.'s (2010:449) study in Belgium that aimed to explore adolescent mothers' perspectives regarding their own psychosocial and health needs, reflected on what the support group she attended meant to her: "It was nice to go to a place where other young people who were in the same boat as me were... I could ask questions, we shared ideas and I learned a lot from them..."

A nursing student who participated in Sekgobela's study (2008:109-110) about pregnancy related challenges encountered by student nurses at the South African military health services nursing college shared this sentiment: "I chose to keep my baby and my friends in the group supported me and understood me. We help each other and we treat each other as adults."

This quote from one of the participants in Naidoo and Kasiram's (2006:344) study which explored the problem of UPs amongst students at the University of Durban-Westville in KwaZulu-Natal, serves as testimony of the value of being part of a support group: "Everybody there [referring to an informal support group at a crisis pregnancy care centre] was so nice and understanding... At school it was as if

there was a gap between me and my friends... I felt like I was from Mars. But in the group... nobody judged me for choosing to have an abortion. We shared the same feelings and concerns...”

Related to Participant F's suggestion was the **suggestion of peer-education** suggested by Participant D. Participant D formulated this recommendation as follows: *“I really feel like maybe people like me, who’ve been through it [referring to her experience of her TOP] can tell their peers, ‘cause, like, when it comes from you... they’ll listen to you but they’ll be like – ‘No, just another lecture on HIV or AIDS and onto pregnancies and everything’. But, if it’s their peer, people normally listen to their peers so... if they get people like me, like students, and people who are like their peers who have been through things like this [referring to the experience of an UP or TOP], they will definitely listen. They’ll listen – ‘you know what, it’s not really easy, it’s not just a walk in the park. You’re not just going to get over it’.”*

The significance of peer support when dealing with a life challenge such as an UP or TOP is consistently emphasised by several scholars, especially in terms of how it can provide support with regard to the academic pressures emanating from this crisis. As is evident from various sources, pregnant students who engaged in peer-facilitated education and support appraised the direct emotional and educational support received as positive, helpful, or constructive (Brittain, Williams, Zapata, Pazol, Romero & Weik, 2015:76, 78; Van Breda, 2011:iv, 25-26; Martin & Oswin, 2010:61; Wilks & Spivey, 2010:281, 285; Romeo & Kelly, 2009:1004-1005; Brosh et al., 2007:4). Despite being pregnant, students continue to pursue their educational goals with peer education and support collaborations between students as peers, educators, and professionals focusing on their physical, emotional, interpersonal, and academic-related needs, and playing a facilitating and encouraging role in addressing some of the needs experienced (Brittain et al., 2015:76; Adams & Williams, 2011:1884; Baird & Porter, 2011:153; Wilks & Spivey, 2010:281).

Related to the suggestion of Participant D about peer-education, was the suggestion for **awareness campaigns** to not only inform students about UP, TOP,

and the consequences thereof, but also where to go for help when confronted with such life challenges.

Participant A recommended: *"...letting the student know that it's okay to ask for help because a lot of students feel, 'I need to do this on my own' [referring to dealing with the UP] and you don't have to. You really don't have to."*

Participant B suggested the following: *"I think... you must organise something. Maybe the awareness or something... to give us information... about the problem and where to get help..."*

Participant D proposed: *"Campaigns like... where... they hear other people's stories. People, who've been through it, people who are their peers. Campaigns like that, where you get people to sit and talk and get information out there... awareness campaigns... You can put a poster... put an advert on TV... on a billboard... get people to tell them – 'eh, this is bad'... Have a child and this is how it is. It's not easy [to] have... an abortion and... peer support and things like that..."*

TSs often receive information on sexual health matters such as safe-sex practices, HIV-prevention, STDs, and pregnancy prevention from university newspapers, through pamphlets being distributed and awareness campaigns, or through discussions in lectures and amongst peers (Adams & Williams, 2011:1876; Miller, 2011:69). Despite all these efforts and information being available, several researchers (in South Africa and abroad) (Steck, 2011:18, 31; Rosen, 2010:18; Ratlabala et al., 2007:30; Naidoo & Kasiram, 2006:350) who focused on the topic of university students' sexual health, found that ignorance, having incorrect information, and holding on to certain beliefs and myths place their sexual health at risk (Steck, 2011:11; Ratlabala et al., 2007:30)

The notion prevailing amongst TSs that they are aware of and knowledgeable about contraception and the reproductive system, and know how to prevent an UP, has been cited as a barrier to reaching out for and accepting support (Miller, 2011:69; Levi et al., 2009:311; Sekgobela, 2008:3). While awareness campaigns

on matters such as sexual health and the encouragement of adopting positive sexual behaviour attitudes at surface level seem to have a positive impact, the research findings and statistics regarding the occurrence and prevalence of unintended pregnancies and TOPs amongst TSs paint a different picture (Svanemyr, Amin, Robles & Greene, 2015:8; Patel & Kooverjee, 2009:560). Despite this, an increase in and improvement of awareness and information related to contraceptive care, unintended pregnancy options and available resources have been found to lead to an increased utilisation of appropriate support services, which in the end benefits the student in the attainment of her educational goals (Van Breda, 2011:26; Brosh et al., 2007:575).

The focus of the discussion now turns to the suggestions for academic-related support to students presenting with an UP and/or a TOP, as forwarded by some of the participants.

c) Category 4.1.3: Suggestions for academic-related support to students presenting with an UP and/or a TOP

The suggestions forwarded by Participant A, B, and F gave rise to this category.

Participant B's suggestion calls for **the amendment of rules/policies to not expel students from the university's residence when they fall pregnant**. She recommended: *"...this thing of that if you are pregnant you must be expelled from the residence. I think they must change that."*

Participant F suggested that **students presenting with an UP should inform their lecturers about it**, so that they could provide assistance. She phrased it as follows: *"The people who are teaching you at some ... it's really good for them to know what you're going through so that they're not going to be shocked at your marks, or treat you somehow, if you tell them it's going to help you as well because you can go to them and tell them what you're struggling in – they'll be able to help."*

Participant A **suggested that students who are pregnant should be allowed to carry on with their studies for as long as possible and be allowed to make or be provided with alternative arrangements when missing a test or an examination.** She proposed: “...*being able to carry on with your studies until, at the latest... of your pregnancy and then, if you do miss a test or an exam when you’re having the baby... write a sick test...*” She also later on in the interview suggested “*then, after... baby’s there, maybe... knowing that there is a crèche or somewhere where baby can stay when you take, when you carry on with your studies...*” Research findings in this regard indicate that the “highest ranked type of needed support” (Burgen, 2010:29) voiced by TSs presenting with an UP and/or TOP was time off (in other words, a few days off after a TOP procedure or childbirth, without being penalised) and childcare (the availability of and access to flexible on-site day care) (Burgen, 2010:29; Arhin & Cormier, 2008:214-215; Brosh et al., 2007:568).

Participant F’s suggestion that students who are pregnant should inform lecturers about it, in order for them to understand the possible drop in their academic performance and provide support, ties in with an observation made by Van Breda (2011:20) when stating that lecturers and academic or support staff are not always aware of the challenges, such as an UP, TOP, or parenthood experienced by some of their students, which could explain the reasons for poor academic results or absenteeism (Van Breda, 2011:20). It has been confirmed that TSs dealing with an UP and/or TOP struggle to function at capacity, cope with academic demands and keep up with assignments, readings and assessments— a situation experienced by them as particularly challenging (Van Breda, 2011:4; Arhin & Cormier, 2008:213).

TSs who receive support from support service structures provided by the university tend to remain in the educational system longer than those who receive limited or no support (Van Breda, 2011:20). Several research studies have confirmed that a supportive institutional environment can serve as inducement to students with UPs and/or TOPs, specifically in terms of attainment of their educational goals (Van Breda, 2011:20; SmithBattle, 2007:365; Zachry, 2005:2596).

Support from fellow students and academic staff in particular in dealing with life challenges are rated as “significantly more helpful” than support from family or other social systems (Van Breda, 2011:6). While it is unlikely for students, in general, to seek or access support from their lecturers, it has been found that those who do benefitted from the support (Van Breda, 2011:iv; Brosh et al., 2007:568). Van Breda’s (2011:20) research study amongst social work students at the University of Johannesburg, Gauteng, in which he explored their experiences of life challenges, indicated in this regard that 83% of the participants in his study who chose to approach their lecturers for support had a positive experience. This is concurrent with the findings of Martin and Oswin (2010:51) who found lecturers and/or academic staff to generally be understanding, supportive, and helpful. When approached by a student experiencing a crisis, they can refer the student to the relevant on-campus support service and may even grant a student’s request to be absent from lectures, or set an alternative date for a test, examination, or the submission of a project.

However, the support offered by lecturers and/or academic staff is normally guided and influenced by the unique set of rules and regulations that each tertiary institution has. Below are some of the general rules and regulations that specifically apply to the occurrence of an UP at tertiary level that were found in the literature consulted (Mbelle et al., 2018:515; Tertiary Institution D, 2015):

- Frequent absenteeism from class or missing an exam requires the submission of a doctor’s note in order for alternative arrangements to be made for a “sick-test” or supplementary exam, or an extension of a deadline for submission of a project.
- Funding allocations are often withdrawn as a result of pregnancy or maternity related absence.
- Students are normally not entitled to maternity leave.
- The utilisation of institutional/student accommodation whilst pregnant is generally only allowed until the student’s fifth or sixth month of pregnancy.
- Babies are normally not allowed in lecture halls or residence rooms.

Lack of or negative lecturer interactions; limited or no faculty support; perceived rigidity by some academic/institutional staff specifically regarding attendance

policies; the inability of tertiary institutions to provide adequate leave for pregnant students/young mothers; as well as concerns about childcare and accommodation and the lack of resources in this regard have been confirmed as factors hindering educational attainment (Mbelle et al., 2018:515; Pugh, AN, 2010:13; Arhin & Cormier, 2008:214-215; SmithBattle, 2007:349; 354).

The discussion of the research findings relating to the experiences, support, and support needs of TSs in relation to their UPs and/or TOPs, as well as their suggestions to inform practice guidelines for psychosocial support, is herewith concluded.

4.4 CHAPTER SUMMARY

In this chapter, the research findings relating to the experiences, support, and support needs of TSs in relation to their UPs and/or TOPs were presented. The suggestions offered by them, based on their experiences as TSs confronted with this phenomenon, for informing practice guidelines for psychosocial support to TSs presenting with an UP and/or TOP were also presented. This presentation was preceded by a detailed discussion of the demographic details of the participants, supported by and compared and contrasted with findings from the body of existing literature. This discussion revealed that, with the exception of one participant who fell in the “young adulthood” category (Lane, 2015:30), all of them were found to be in adolescence and/or late adolescence (Isdale et al., 2016; Jordán-Conde et al., 2014:356; Sigelman & Ryder, 2006:305; Santrock, 1998:24) and in either their second or third year of study when the UP and/or TOP occurred. The majority of the participants (four of the six students) described their hometown (the province/area where they came from originally) as semi-urban and five of the participants indicated that they were making use of institutional/university accommodation while studying and when the UP and/or TOP occurred. In terms of the ethnic distribution of the participants, the majority of them indicated their race as Black, while the older participant (Participant A) identified herself as Coloured. All of the participants indicated that English was not their first/home language, but they confirmed that they were fluent in and comfortable with English. The discussion of the findings relating to the demographic details of the TS-participants

was followed by a tabulated overview (see Table 4.5) of all of the themes, sub-themes, and categories that emerged from the data analysis process.

In Theme One, the focus was on the circumstances of the participants leading up to their UPs, as well as the feelings, emotional reactions, and life changes experienced as a result of the UP. This theme unfolded in four sub-themes which addressed their accounts of the nature of their relationships prior to the occurrence of their UPs; their explanations as reasons for the occurrence of their UPs; the feelings and emotional reactions experienced on confirmation of the suspicion of their UPs; as well as their accounts of how their lives changed following the UP-experience.

Theme Two focused on the outcome of the UP, namely the decision taken by each TS-participant with regard to her UP. This theme was divided into three sub-themes, which illuminated the decision to either continue with the UP or to terminate the UP. The factors that influenced the decision, as well as the feelings and emotional reactions experienced following the decision taken, were also presented.

Theme Three addressed the participants' accounts of the nature of the support received in relation to their UPs and/or TOPs. This theme unfolded in three sub-themes which highlighted their utilisation of professional and informal support, both on and off campus, for their UP and/or TOP transitions after the suspicion of the UP had been confirmed; the positive and negative experiences related to the support sought and received; as well as their accounts of what they would have liked to be different in terms thereof.

The last theme, Theme Four, consisted of a presentation of the suggestions offered by the participants for psychosocial support to TSs presenting with an UP and/or TOP. This theme unfolded in one sub-theme and three categories which illuminated their suggestions for medical and counselling support, peer-support and education; awareness campaigns; as well as academic-related support to students presenting with UPs and/or TOPs. Suggestions for students to utilise this support were also made.

The above-mentioned themes, sub-themes and, where applicable, categories were substantiated by direct quotations taken from the transcripts of the interviews that were conducted with the participants. It was also contextualised within the body of knowledge available; in other words, a literature control was provided. The latter served as a verification tool for establishing the credibility and trustworthiness of the research findings (Creswell, 2014:202; Green, 2014:36; Holloway & Wheeler, 2010:2) and it also confirmed or contrasted what other researchers have found in this regard.

In the next chapter the research findings relating to the perceptions of the participating SPs regarding the experiences and support needs of TSs with UPs and TOPs are presented. The scopes of support services offered by them and their suggestions for informing practice guidelines for psychosocial support to TSs presenting with UPs and TOPs are also presented.

CHAPTER FIVE:

RESEARCH FINDINGS – SPs’ PERCEPTIONS OF THE EXPERIENCES AND SUPPORT NEEDS OF TSs PRESENTING WITH UPs AND TOPs, THE SCOPES OF SUPPORT SERVICES OFFERED BY THEM, AND SUGGESTIONS INFORMING PRACTICE GUIDELINES FOR PSYCHOSOCIAL SUPPORT

5.1 INTRODUCTION

In the previous chapter of this research report, the research findings based on the TS-participants’ accounts of their experiences, support, and support needs related to their UPs and/or TOPs, as well as their suggestions for support to other students in similar situations with the view of informing practice guidelines for psychosocial support for this purpose, were presented. In this chapter, the research findings that emerged from the focus group discussions and the semi-structured, individual interviews conducted with the sampled SPs are presented. These findings focus on the SPs’ perceptions related to the experiences and support needs of TSs with UPs and TOPs, the scopes of the support services offered by them to said students, as well as their suggestions for informing practice guidelines to TSs presenting with an UP and/or TOP.

Before presenting the mentioned research findings, the SP-participants’ demographic details are provided, as well as a tabulated overview of the themes, sub-themes, and categories under which the research findings will be introduced.

5.2 THE DEMOGRAPHIC DETAILS OF THE SP-PARTICIPANTS

A total of 62 SPs, comprising of social workers, psychologists, healthcare professionals, and volunteer counsellors rendering support services to TSs with UPs and TOPs in the geographically demarcated areas for the study were initially invited to participate in this research project (my motivation for delimiting the boundaries of the populations of this study to Gauteng was presented in Section 2.5.1). Of the 23 SPs who finally agreed to participate in the study, 13 were

employed at the four participating tertiary institutions in Gauteng, while the rest were volunteer counsellors at the participating CPCC. Their demographic details with reference to the aspects of age, gender, occupation, highest qualification, as well as the number of years (practice experience) rendering support services to TSs (presenting, amongst others, with UPs and/or TOPs) are presented below, with Table 5.1 focusing on the SPs from the participating tertiary institutions and Table 5.2 on the volunteer counsellors from the participating CPCC.

Table 5.1: Demographic details of the SPs from the tertiary institutions

SP's occupation and tertiary Institution employed at	Code name	Gender	Age	Highest educational qualification	Number of years providing services to TSs with UPs and/or TOPs
Social Worker (Institution C)	SW-1	Female	62	D Phil (Social Work)	16+ years
Social Worker (Institution D)	SW-2	Female	27	B.A. (Social Work)	1-5 years
Educational Psychologist (Institution A)	Ed-Psych-1	Female	27	M.A. (Educational Psychology)	1-5 years
Educational Psychologist (Institution A)	Ed-Psych-2	Female	32	M.A. (Educational Psychology)	6-10 years
Educational Psychologist (Institution A)	Ed-Psych-3	Female	44	M.A. (Educational Psychology)	11-15 years
Educational Psychologist (Institution B)	Ed-Psych-4	Female	34	M.A. (Educational Psychology)	1-5 years
Counselling Psychologist (Institution A)	C-Psych-1	Female	56	M.A. (Counselling Psychology)	16+ years
Counselling Psychologist (Institution C)	C-Psych-2	Female	41	M.A. (Counselling Psychology)	6-10 years
Counselling Psychologist (Institution D)	C-Psych-3	Male	25	M.A. (Counselling Psychology)	1-5 years
Counselling Psychologist (Institution D)	C-Psych-4	Female	34	M.A. (Counselling Psychology)	6-10 years
Clinical Psychologist (Institution A)	Clin-Psych	Female	36	M.A. Clinical Psychology	6-10 years
Healthcare Practitioner (Institution A)	HCP-1	Female	51	B-degree (Nursing Science)	6-10 years
Healthcare Practitioner (Institution D)	HCP-2	Female	48	M.A. (Nursing Management)	11-15 years

As evident from Table 5.1 above, the ages of the SPs from the participating tertiary institutions ranged from 25 to 62 years of age. At the time of the fieldwork, seven of them fell in the age group 30 to 49 years of age; three of them were older than 50 years; and three participants were younger than 30 years of age.

Regarding the gender distribution of the SP-participants, one is male and the rest are female. This gender distribution is not uncommon, with several authors noting that the nurturing/caring attributes attributed to women and the functions acquired by them whilst growing up may play a role in them being drawn to the so-called “nurturing” elements of “caring professions”, resulting in them pursuing a career in psychology, nursing, social work, teaching, or counselling (Ivanovic, Swift & Callahan, 2015:338; Cunico, Sartori, Marognolli & Meneghini, 2012:2022; Vorkapić & Mustapić, 2012:190; Lovelock, Lyons & Powell, 2004:73).

Pease (2011:406-407, 414), in referring to social work specifically, points to the gender imbalance as a “continuing issue facing social work”, since social work has been defined as a “female profession” for a long time (Pease, 2011:407) as the nurturing and caretaking functions of the profession are perceived to be “women’s activities” (Pease, 2011:407).

Focusing on the highest educational qualification category of the SP-participants (depicted in Table 5.1), it became clear that 12 of the 13 participants were in possession of a post-graduate qualification. In terms of number of years’ experience in rendering professional services to TSs with UPs and/or TOPs in the field of higher education, nine of the 13 participants had more than five years’ experience in this regard.

The demographic details of the volunteer counsellors from the participating CPCC are presented in Table 5.2.

Table 5.2: Demographic details of the volunteer counsellors from the CPCC

Code name for volunteer counsellor-participant	Gender	Age	Highest educational qualification (Name of the post-matric/tertiary qualification indicated in brackets, where applicable)	Number of years providing volunteer counselling services to TSs with UPs and/or TOPs
VC-1	Female	42	M.A. Degree (Social Work)	6-10 years
VC-2	Female	44	BEd Degree (Education)	2-5 years
VC-3	Female	33	National Diploma (Photography)	2-5 years
VC-4	Female	56	Diploma (Pastoral Counselling)	6-10 years
VC-5	Female	61	Matric	6-10 years
VC-6	Female	38	BIT Degree Information Technology	2-5 years
VC-7	Female	43	B-Degree (Education)	2-5 years
VC-8	Female	54	Matric	6-10 years
VC-9	Female	48	BCom Degree (Commerce)	2-5 years
VC-10	Female	64	Certificate (Pastoral and Lay Counselling)	6-10 years

All the volunteer counsellors who participated in this study are female – this is similar to the trend observed amongst the SP-participants. This also corroborates a conclusion drawn by Rek and Dinger (2016:438) who, in their exploration of the interpersonal characteristics of volunteer counsellors, found that volunteers predominantly tend to be female and that the average age of a volunteer is 52. In my study, the ages of six of the volunteer counsellors at the time of the fieldwork were between 40 and 59 years.

As is evident from Table 5.2 (above), eight out of the 10 volunteer counsellors indicated that they are in possession of a post-matric/tertiary qualification. One of the volunteer counsellors, Participant VC-1, has a Master's degree in Social Work. Participants VC-2 and VC-7 have teaching qualifications, while Participant VC-6 holds a BIT-degree. Participant VC-9 indicated that she holds a BCom-degree. One of the participants (VC-3) is a qualified photographer and two other participants (VC-4 and VC-10) completed a certificate and a diploma course in Pastoral and Lay Counselling, respectively.

The basic requirement for service delivery at the participating CPCC is the successful completion of a specialised training programme⁴³, as well as a commitment to render services (crisis pregnancy counselling) at the centre and/or its satellite offices for a minimum period of one year (a minimum of four hours of counselling per week, excluding the weekly supervision and/or debriefing sessions, is generally required in this regard). Volunteer counsellors who wish to enrol for the advanced training programme, namely the Post-Abortion Counselling Training Programme⁴⁴, may do so once they have rendered crisis pregnancy counselling services for a minimum period of one year.

All of the volunteer counsellors who participated in this research study successfully completed the basic training programme ("Equipped to serve") offered by the CPCC and six of the participants successfully completed the advanced training programme ("The Journey: A road to post-abortion recovery").

All the participants furthermore indicated that they had a minimum of two years' experience as a volunteer counsellor with five of the participants having six to 10 years' experience in the field of crisis pregnancy and/or post-abortion counselling. In an attempt to further provide background information on the volunteer counsellors sampled for inclusion in this study, I include the feedback and comments of the Director of the participating CPCC received during the staff meetings conducted by the management of the centre and which I was fortunate enough to be allowed to attend. She remarked: "The average volunteer counsellor at the pregnancy care centre is usually an older female with reduced responsibilities, whose children finished school/left home and who has a wish or

⁴³ All volunteer counsellors, regardless of their educational training/background and/or profession, have to complete a specialised training programme widely used by CPCCs worldwide, namely "Equipped to serve". The programme, which is updated regularly and is currently being re-written to make it culturally relevant for South Africa, is developed by Philkill and Walsh from the USA (2002). The training programme consists of 49 hours of academic training, as well as a written and practical exam. Volunteer counsellors normally first have to observe five to eight counselling sessions, after which they conduct counselling under supervision and only then may they proceed with counselling clients on their own. Weekly supervision is compulsory.

⁴⁴ This training programme, referred to as "The Journey: a road to post-abortion recovery", is based on Freed and Salazar's (1993) "Healing Steps to post-abortion recovery" and was developed by Joanna Thompson from Care Confidential in the UK (2005). This training programme consists of a one-week training programme, as well as a written and practical exam (one counselling session under supervision). Weekly supervision is also compulsory.

desire to devote her time, energy and passion to a worthy cause” (The Director, CPCC, 2014).

She added that, based on observations over many years, people of various backgrounds education-wise, and for a variety of reasons, choose to volunteer specifically at a CPCC. Some of the reasons offered by the Director and Staff of the CPCC were as follows:

- Some volunteer for altruistic reasons, such as “giving something back” to society, and making a difference, as a gesture for being so fortunate and blessed themselves.
- Others are motivated to volunteer because of the fact that their own struggles and losses in life have sensitised them to develop an empathy for and an ability to reach out to others to “help out”, as they received help when they were in dire straits (Meetings with Management and Staff; CPCC, Pretoria. 2014, August 22 & 2009, October 26 & November 9).

The remarks made by the Director and staff of the CPCC resonate with the views of several scholars stating that the majority of volunteers who become involved in supporting women with UPs and/or TOPs are other women hoping to make a difference in these women’s lives by offering assistance in addressing their material, spiritual, or emotional needs (Balaluka, Nabugobe, Mitangala, Cobohwa, Schirvel, Dramaix & Donnen, 2012; Kelly 2012:205, 228; Akintola, 2010:2).

The presentation of the biographical information on the SP-participants is herewith concluded. A discussion of the themes, sub-themes, and categories that emerged from the data analysis process will now be presented.

5.3 THE THEMES, SUB-THEMES, AND CATEGORIES THAT EMERGED FROM THE DATA ANALYSIS PROCESS

As discussed earlier in this research report and depicted in Chapter Three (see Table 3.4), four once-off focus group discussions were conducted. The 10 volunteer counsellors were divided into two focus groups. At Tertiary Institution A, five of the SPs participated in a focus group discussion, while three were engaged

in a focus group discussion held at Tertiary Institution D. Five semi-structured, individual interviews were conducted. The Healthcare Practitioners from Tertiary Institution A and D requested to be interviewed individually. At Tertiary Institution B an Educational Psychologist opted to be interviewed individually, and at Tertiary Institution C a Social Worker and Counselling Psychologist took this option as well. The data obtained were thematically analysed using Tesch's framework for data analysis (Tesch, in Creswell, 2014:198) by myself and an independent coder (appointed for this purpose), after which my study's supervisor facilitated a consensus discussion during which we consolidated the themes, sub-themes, and categories that emerged from the data analysis process to be reported further on in this chapter.

A tabulated overview of the themes, with their accompanying sub-themes and categories, is presented in Table 5.3.

Table 5.3: Overview of themes, sub-themes and categories that emerged from the data analysis process as consolidated during the consensus discussion

THEME ONE: SPs' PERCEPTIONS ABOUT THE PREVALENCE, IMPACT, AND REASONS FOR THE OCCURRENCE OF UPs AND TOPs AMONGST TSs	
SUB-THEMES	CATEGORIES
Sub-theme 1.1: SPs perceive UPs and/or TOPs to be a prevalent social phenomenon amongst TSs	-
Sub-theme 1.2: The perceptions of SPs about the impact of UPs and TOPs on TSs	-
Sub-theme 1.3: SPs' perceptions of the reasons for the occurrence of UPs and/or TOPs amongst TSs	Category 1.3.1: Engaging in high-risk sexual behaviour; contraceptive issues; peer pressure; lack of knowledge regarding sexuality; and unavailability of support services as reasons for the occurrence of UPs amongst TSs
	Category 1.3.2: Academic, financial, parental, and/or partner pressures and lack of information on options to manage an UP as reasons for TOPs amongst TSs
THEME TWO: SPs' PERCEPTIONS OF THE EXPERIENCES AND SUPPORT NEEDS OF TSs PRESENTING WITH UPs AND/OR TOPs	
SUB-THEMES	CATEGORIES
Sub-theme 2.1: SPs' perceptions of the feelings and emotional reactions experienced by TSs presenting with UPs and/or TOPs	Category 2.1.1: SPs perceive TSs as being pressured and experiencing feelings of confusion about the UP and the management thereof
	Category 2.1.2: SPs perceive TSs to experience feelings of loneliness and lack of support

	Category 2.1.3: SPs perceive TSs as being afraid of the negative reactions of and abandonment by their significant others
	Category 2.1.4: SPs perceive TSs as experiencing feelings of guilt and shame
	Category 2.1.5: SPs perceive TSs as experiencing feelings of shock upon the confirmation of the suspicion of an UP
	Category 2.1.6: SPs perceive TSs as experiencing trauma as a result of the TOP-procedure
	Category 2.1.7: SPs perceive TSs as experiencing academic and financial pressure and stress
Sub-theme 2.2: SPs' perceptions of the support needs of TSs presenting with UPs and/or TOPs	Category 2.2.1: SPs perceive TSs presenting with UPs and/or TOPs to be in need of counselling and support
	Category 2.2.2: SPs perceive TSs presenting with UPs and/or TOPs to be in need of on-campus medical support
	Category 2.2.3: SPs perceive TSs presenting with UPs and/or TOPs to be in need of academic support
THEME THREE: THE SCOPES OF THE SUPPORT SERVICES OFFERED BY SPs TO TSs PRESENTING WITH UPs AND/OR TOPs	
SUB-THEMES	CATEGORIES
Sub-theme 3.1: SPs offer counselling as support service to TSs presenting with UPs and/or TOPs	Category 3.1.1: The provision of crisis pregnancy counselling, post-abortion counselling, and bereavement counselling
	Category 3.1.2: Referral to and liaison with internal and external resources and the student's significant others
	Category 3.1.3: Life skills and psycho-education
Sub-theme 3.2: SPs offer medical support to TSs presenting with UPs and/or TOPs	
THEME FOUR: SPs' ACCOUNTS OF THE RESOURCES AVAILABLE AND OBSTACLES ENCOUNTERED IN RENDERING SUPPORT SERVICES TO TSs PRESENTING WITH UPs AND TOPs	
SUB-THEMES	CATEGORIES
Sub-theme 4.1: Resources available to assist SPs in their service delivery to TSs presenting with UPs and/or TOPs	Category 4.1.1: Peer/collegial support as a resource
	Category 4.1.2: Specialised and on-going training as resource
	Category 4.1.3: Being located in the right spot and having private offices available as a resource for service delivery
	Category 4.1.4: Having the option to refer students and having resources to refer to as a resource for service delivery
Sub-theme 4.2: Obstacles encountered by SPs in their service delivery to TSs presenting with UPs and/or TOPs	Category 4.2.1: Lack of finances as an obstacle to service delivery
	Category 4.2.2: Staff-shortages and language and cultural barriers as obstacles to service delivery
	Category 4.2.3: The location and distance between student service departments at the tertiary institutions as an obstacle for service delivery

	Category 4.2.4: Facilitation of the termination of an UP with relative ease by the Choice on Termination of Pregnancy Act 92 of 1996 (South Africa 1996) as an obstacle to service delivery Category 4.2.5: TSs' non-utilisation of available resources as an obstacle to service delivery Category 4.2.6: Tertiary institutions' residential policies with regard to student pregnancy as an obstacle to service delivery
THEME FIVE: SPs' SUGGESTIONS FOR INFORMING PRACTICE GUIDELINES FOR PSYCHOSOCIAL SUPPORT TO TSs PRESENTING WITH AN UP AND/OR TOP	
SUB-THEMES	CATEGORIES
Sub-theme 5.1: SPs' suggestions on the format and content of psychosocial support to TSs presenting with an UP and/or TOP	-
Sub-theme 5.2: SPs' additional suggestions for the offering of psychosocial support to TSs presenting with an UP and/or TOP	Category 5.2.1: Psychosocial support to TS should be enhanced through better networking, cooperation, and referrals between tertiary institutions, significant others, and community resources
	Category 5.2.2: The practice guidelines for psychosocial support to TS presenting with an UP and/or TOP should be user-friendly, holistic, flexible, and disseminated to all relevant role players
	Category 5.2.3: The practice guidelines should inform tertiary institutions' policies related to student pregnancy
UNIQUE THEME: SPs RENDERING SUPPORT SERVICES TO TSs PRESENTING WITH UPs AND/OR TOPs SHOULD RECEIVE SPECIALISED AND ON-GOING TRAINING (SPECIFICALLY RELATED TO THE PHENOMENON)	

The themes with their related sub-themes and categories will now be introduced. Excerpts from the participants' accounts gathered by way of employing the mentioned data collection methods will be provided in substantiating the themes, sub-themes, and/or categories that will be presented. The respective themes, sub-themes, and categories and their supporting storylines will furthermore be compared and contrasted with existing theories and previous research/literature in order to verify the trustworthiness and credibility thereof (Holloway & Wheeler, 2010:28).

5.3.1 Theme One: SPs' perceptions about the prevalence, impact, and reasons for the occurrence of UPs and TOPs amongst TSs

This theme, which unfolded in three sub-themes, emerged from the responses of the SPs after the following question was posed to them: *"What are your views in general about the phenomenon of UPs and TOPs amongst TSs?"*

This theme relates to the aspect of the *"Situation"* in Schlossberg's Model for analysing human adaptation to transition, also referred to as the Transition Process Model (Anderson et al., 2012; Schlossberg, 2011; Schlossberg, 1981). The utterances of the SPs in this regard provide an account of the TSs' situations surrounding the UP and/or the TOP in that they shared their perceptions related to the reasons for this phenomenon and also elaborated on the impact of these events on the students' stress levels and academic and social functioning.

5.3.1.1 Sub-theme 1.1: SPs perceive UPs and/or TOPs to be a prevalent social phenomenon amongst TSs

From the participants' feedback (provided below) in response to the question above, they perceive UPs and/or TOPs amongst TSs to be quite prevalent.

"...my view is that... it's a very, very sad situation [referring to the occurrence and prevalence of UPs and TOPs] in our country that I think is much, much bigger than we can anticipate" [VC-4].

"I think it's [referring to the occurrence and prevalence of UPs and TOPs] quite a huge problem... this is happening quite a lot amongst the age groups that do come to university... And we see it a lot also amongst first year students. And I think it's a problem that is increasing all the time. And I think it also reflects the inability in society as well" [VC-5].

"...it [referring to the occurrence and prevalence of UPs and TOPs] is very prevalent... I don't have numbers, but... it happens quite frequently... Unplanned pregnancy... and abortions... it's really a huge problem" [C-Psych-2].

“...what I’ve observed – this year I think the numbers are going down, they’re really going down, unlike the past years we had... you know we used to have a lot of students who came in with unplanned pregnancy. Maybe even the use of condoms has brought that down” [HCP-1].

With the exception of HCP-1 who noted a decline in the number of TSs presenting with UPs and/or TOPs, the general consensus amongst the SPs was that the prevalence of this phenomenon seems to be quite widespread and problematic.

Their perceptions resonate with various research findings in this regard (also elaborated upon and presented in Section 1.1.1.1) which describe the prevalence of and increase in this phenomenon amongst university/college students, nationally and internationally, as a major cause for concern (Bongaarts & Casterline, 2013:154; Miller, 2011:69-70; Yunos, 2010:4; Naidoo & Kasiram, 2006:343).

Thomas (2012:2-3) holds the view that UP is “a widespread problem with far-reaching implications”, specifically amongst TSs and he purports that UPs “account for more than 90% of all abortions”.

Tied to the prevalence of UPs and TOPs amongst TSs, the participants shared their perceptions about the impact of this phenomenon on the academic and personal wellbeing of said client system group, which will be presented as the next sub-theme.

5.3.1.2 Sub-theme 1.2: The perceptions of SPs about the impact of UPs and TOPs on TSs

The negative consequences and impact of UPs and/or TOPs on TSs’ overall health and wellbeing is emphasised by several scholars (Wise et al., 2017:10; Mantell et al., 2015:1133; Tabane & Mmapheko, 2015:4; Bradshaw & Slade, 2013:932) and was also presented in Chapter One (Section 1.1.1.3, 1.1.1.4 & 1.1.2.5). Tabane and Mmapheko (2015:4) encapsulate this when stating that the experience of an UP or TOP has the potential to disrupt the equilibrium of a TS’s

academic, social, relational, and family life. HCP-2 echoes the authors' view when admitting that the impact of an UP or TOP is *"...huge... a lot... the impact could be physical, emotional, social, academic, financial..."*

SW-1 explained this sad state of affairs along the following lines: *"At this stage I see it [referring to the occurrence and prevalence of UPs and TOPs] as a very big problem... it really, really concerns me... an unintended pregnancy or abortion can destroy a young girl's life..."*

Her concern is echoed by VC-2, who stated: *"... this [referring to the occurrence and prevalence of UPs and TOPs] is something that's very disruptive in their [referring to TSs] lives. Everything changes around them... The one thing we can all agree on is that an unplanned pregnancy equals a change of life. Nothing is... will ever be the same again..."*

An UP and/or a TOP is a challenging and traumatic life experience for many a TS, causing severe stress, bringing about financial worries, and influencing their academic performance and personal wellbeing in a negative way (Moore et al., 2017:108; Wise et al., 2017:9; Kjelsvik & Gjengedal, 2011:171; Van Breda, 2011:4; Yunos, 2010:53).

5.3.1.3 Sub-theme 1.3: SPs' perceptions of the reasons for the occurrence of UPs and/or TOPs amongst TSs

This sub-theme focusing on the SPs' perceptions of the reasons for the occurrence of UPs and/or TOPs amongst TSs closely relates to the reasons provided by the TS-participants (see Section 4.3.1.2 and 4.3.2.2). It is suggested that these sections be read together, as well as with the overview of the literature presented in this regard (see Section 1.1.1.2, 1.1.2.1 and 1.1.2.4).

This sub-theme is branched out into two categories, with the first focussing on UPs and the second on TOPs, as will be presented next:

- a) Category 1.3.1: Engaging in high-risk sexual behaviour; contraceptive issues; peer pressure; lack of knowledge regarding sexuality; and unavailability of support services as reasons for the occurrence of UPs amongst TSs

In substantiating the aspects mentioned in the category, the following excerpts taken from the transcribed interviews of the focus group discussions and individual interviews are provided:

VC-6 mentioned: “...*first year and second year students... [when they] come to [a] tertiary institution... [It might be the] first time that they are away from their parents... [they] have this freedom and engage... in unprotected sex [sometimes ending] in pregnancy and other diseases.*”

Ed-Psych-1 also pointed to TSs engaging in unprotected sex and having multiple sex partners: “... *they [referring to TSs] don't take precautions... they don't think about the consequences of their actions... sleeping around, without protection...*”

SW-2 remarked: “...*It's almost like synonymous with university culture... you do lots of drinking, you have lots of sex, and have lots of parties...*”

HCP-2's perception was as follows: “...*there are lots of campaigns trying to teach students about having safe sex... but I think the practice of safe sex is not happening.*”

The SPs' statements about engaging in unprotected sex and excess drinking that increases high-risk sexual behaviour correspond with similar views held by various scholars (Mchunu et al., 2012:427; Seutlwadi et al., 2012:46; Adams & Williams, 2011:1881; Miller, 2011:69; Abiodun & Balogun, 2009:148).

Apart from the SPs' perceptions of TSs' engagement in high-risk sexual behaviour and practices, they also perceived their naivety, ignorance, carelessness, negative attitudes towards contraception, contraceptive failure, and lack of knowledge about contraceptive options as reasons for the occurrence of UPs amongst this cohort. The following storylines speak to this:

“... our students... somehow... are very ignorant and naive and they don’t think they are going to fall pregnant... in spite of everything [referring to the provision of information and contraceptives] that is done...” [C-Psych-2].

“...There’s genuinely a group of students who just don’t care about their sexual health and wellbeing... I see it every day... many girls just... never, ever take responsibility for their own sexual health and looking after themselves” [VC-10].

I find that many students just don’t want to use contraception... they are so negative towards it... some say that it [referring to the contraceptive pill] makes them sick or that they or their partners do not like using a condom” [C-Psych-1].

“...or... they only use protection occasionally... or wrongly... I saw this student, who came to me every month for the contraceptive pill, but she didn’t use it as prescribed... then they don’t understand why it’s not working... and she fell pregnant...” [HCP-1].

“I had this student who got pregnant and then went home to deliver the baby, came back. Within three months after she was back... she was pregnant again. So, I asked her, ‘How did it happen? What – didn’t you know that you’ll fall pregnant?’ She said ‘No’... because she just gave birth, she thought that she will not be that fertile... she didn’t know that she had to take a contraceptive and... she didn’t know that there actually are many different types of contraceptives” [VC-8].

Embracing negative attitudes towards contraception and harbouring beliefs such as being at low risk of falling pregnant, that contraceptive use in a relationship is a sign of mistrust and infidelity, and that sex with a condom is less pleasurable, together with the infrequent and/or incorrect use of contraceptives or not knowing about the contraceptive options available, as referred to by the SP-participants, are cited as major barriers hindering the prevention of UPs (Coetzee & Ngunyulu, 2015; Mchunu et al., 2012:427; Seutlwadi et al., 2012:46; Adams & Williams, 2011:1881; Miller, 2011:71; Aujoulat et al., 2010:449; Yunos, 2010:42; Ma, Ono-Kihara, Cong, Xu, Pan, Zamani, Ravari & Kihara, 2008:110).

Several scholars aver that university students have sufficient knowledge to their avail about sexual and reproductive health, contraception, and relationships, as well as resources to support and assist them in this regard, yet they seem not put this to good use and appear to be uniformed in these matters (Coetzee & Ngunyulu, 2015; Mchunu et al., 2012:433; Adams & Williams, 2011:1882; Skinner et al., 2009:55; Abiodun & Balogun, 2009:147; Sekgobela, 2008:3; Patel & Kooverjee, 2007:552). The SP-participants had a similar view and perceived many TSs as lacking knowledge about their own sexuality, reproductive health, and the availability of support, which they perceived as reasons for UPs as deduced from their accounts below.

“...Many girls walk around here with the most archaic ideas about what contraception is... they really don’t know how it works, where they can get it... they can get it for free, they can get information about it at the clinics” [VC-1].

“I find that many students are so ignorant about their own bodies and they don’t take responsibility for their sexual health” [Clin-Psych].

“And then I think also because a lot of the pregnancies occur... when they’re so young they don’t have a lot of information about it... or about them... you know, how does one really get pregnant... What’s going to happen now to my body? What is it like? ...and then of course... if I do fall pregnant, what do I do, where do I go, where can I get help?” [VC-9].

“...Oh and don’t forget about the peer pressure... the girls will say, ‘but all my friends are doing it’ [referring to sexual intercourse], or ‘my boyfriend doesn’t like the condom’... I see it with the residence students a lot... they influence each other... we had four pregnant students in one residence recently... all of them engaged in unprotected sex” [SW-1].

In latching on to the topic of peer pressure mentioned by SW-1, Yunos (2010:41) reiterates the influence and significant role of peer pressure in the prevalence of and increase in UPs amongst TSs. In her study conducted amongst 20 female students at the University of KwaZulu-Natal, South Africa, with the purpose of

exploring the reasons for the high fertility rates and high levels of pregnancy among young people (Yunos, 2010:41-42), she arrived at the following salient conclusions: the sudden freedom associated with student life, with many students being away from home and lacking guidance from their elders, could cause them to turn to their peers for guidance and advice, making them more susceptible to be influenced by their surroundings and/or peers. Some of the participants in her study were under the impression that “all students are having sex” and that “sexual activity on campus is normal” (Yunos, 2010:42). They admitted to engaging in sexual activities and being coerced into do so because of the pressure from their friends and partners and “to fit into the group” (Yunos, 2010:42). They mentioned that men do not want to be in a relationship that does not include sex and indicated that their partners made them feel guilty by questioning their love if they refused to engage in sex or unprotected sex (Yunos, 2010:41). Yunos (2010:42) also concluded that succumbing to peer and/or partner pressure to engage in sexual activity or to practice unsafe sex stems from a fear of abandonment and/or an intense need for acceptance.

This corresponds with some of the psychosocial challenges inherent to the particular developmental stage that most TSs find themselves in. In searching for their own identity, they could be defining themselves in the context of their peers and significant others and in the context of greater freedom, which inevitably includes more opportunities for sexual exploration, which could result in the occurrence of UPs (SAACHDE, 2010:4; Yunos, 2010:42).

- b) Category 1.3.2: Academic, financial, parental, and/or partner pressures and lack of information on options to manage an UP as reasons for TOPs amongst TSs

In substantiating the aspects referred to in this category, the following SPs' accounts are provided:

“... some girl students... would say, ‘it would be fine to have a baby, but not now... because now I’m a student’. So it’s... being a student... having the studies, the pressure... causing them to have an abortion... For example, because they’re in

first year, they believe it's going to mess up their university studies... and they feel like they don't have any other option... just to end the pregnancy" [VC-5].

"... the student will probably choose abortion because it seems to be the best way of... being able to continue with her studies... I find that many students confronted with an unplanned pregnancy are afraid that they will not be able to continue with their studies if they continue with the pregnancy... They don't know how they can combine a pregnancy and a baby with the academic demands..." [Ed-Psych-1].

"And the bursaries... a few students that said... 'I got this bursary'... and she is not allowed to get pregnant otherwise she will lose this bursary..." [VC-7].

"Many students are really struggling financially... they know that there is no money, no financial support, and that might motivate them to rather abort, because what are they going to do?" [SW-1].

"...most of the students that I saw for counselling... they said they actually have no reason to go for an abortion except for 'my father will abandon me, my father will kill me, my father will chase me out of the house' – the father is like... 'You may not get pregnant', so [she] rather go [sic] for an abortion... than to tell her father that she's pregnant..." [VC-2].

"...And also... I mean... I think quite often the families are not supportive around it, so they can't speak to anybody, so they just go and do it [referring to TOP]" [VC-8].

"...and then of course the boyfriend not being supportive, or denying paternity... I have seen that... the boyfriend often pressures them [referring to the pregnant partners] to go for an abortion, or threatens to leave them if they don't abort..." [HCP-2].

"I found that many students are unaware of the options that are available to them; they don't know about adoption and... single parenting scares them. They also don't know what exactly a TOP entails. They don't have sufficient information and

it's sad that they then base their decision to terminate on this lack of information and support" [SW-2].

Concerns about the impact of having a child has on TSs' educational attainment are cited as one of the most important determinants for the decision to terminate an UP (Mphatswe et al., 2016:155; Pestvenidse et al., 2016:87). The notion prevails that having an abortion mitigates the educational disadvantage associated with an UP and serves to protect and maintain TSs' educational opportunities (Mphatswe et al., 2016:155; Miller, 2011:69; Steck, 2011:18; Van Breda, 2011:24; Fergusson et al., 2007:11). In further substantiating the aspect of academic pressures resulting from an UP as alluded to by some of the participants (above), Oriji, Jeremiah and Kasso (2009:202), in their Nigerian-study amongst 451 undergraduate students, established that 47% of their participants indicated that they terminated their UPs because they wanted to "protect their educational career". The purpose of the mentioned study was to determine the proportion of undergraduates who had induced abortions, as well as the contributing factors in this regard (Orij et al., 2009:200). Yunos (2010:67), in her study conducted at a university in KwaZulu-Natal alluded to earlier in this Chapter, came to a similar conclusion with the majority of her participants emphasising the negative consequences of an UP on education and expressing their concern that an UP would "lead to an interruption of education" (Yunos, 2010:67).

The role of financial constraints and pressures in students favouring TOP has been reported by a number of scholars, who point out that TSs generally have limited economic resources and major concerns related to the inability to support a child (Van Breda, 2011:23). Other reasons, such as unemployment and study-debt, could furthermore prompt their decision to terminate an UP (Macleod et al., 2016:1101; Mphatswe et al., 2016:155; Van Breda, 2011:26; Yunos, 2010:52; Macleod & Tracey, 2009:13). In addition, the threat of financial support from parents and/or a partner being withdrawn or a study loan/bursary being revoked seems to intensify the anxiety experienced, leaving many TSs feeling that TOP is the only viable option to arrest the situation of an UP (Ekstrand et al., 2009:176).

Persuasion and pressure from significant others, such as the parents and/or partner, to terminate an UP is not uncommon in the context of TSs (Mavis et al., 2015:1155; Ralph et al., 2014:430; Lohan et al., 2011:1512). Fear of negative comments, reactions, and/or rejection compounds the feelings of ambivalence and confusion many female TSs experience when confronted with an UP. Pair this with the pressures mentioned and the decision to terminate an unintended pregnancy tends to become inevitable (Ralph et al., 2014:430; Adams & Williams, 2011:1882; Arhin & Cormier, 2008:214).

The aspect of TSs not knowing about the different options available to deal with an UP, such as parenting, adoption, or TOP, despite relatively easy access to this information (Grey, 2015:38; Sekgobela, 2008:1), has also been alluded to earlier in this research report (see Section 1.1.1.5 and 4.3.2.2 in this regard). This lack of information on the different options available to deal with an UP, also alluded to by SW-2 above, underscores the importance of informing TSs with an UP about the different options available when dealing with this eventuality (Coetzee & Ngunyulu, 2015; Grey, 2015:737; Adams & Williams, 2011:1883).

The presentation of Theme One centring on the perceptions of the SP-participants about the prevalence and impact of, as well as the reasons for, the occurrence of UPs and TOPs amongst TSs is herewith concluded. In the next theme the focus will be on the SPs' perceptions of the experiences and support needs of TSs in relation to their UPs and/or TOPs.

5.3.2 Theme Two: SPs' perceptions of the experiences and support needs of TSs presenting with UPs and/or TOPs

The SPs' verbal accounts which gave rise to this theme stemmed from the following question that was directed to them during the focus group discussions and semi-structured, individual interviews conducted with them: "*What are your perceptions on the experiences and support needs of TSs in relation to their UPs and TOPs?*"

This theme ties in with the aspect of the “*Self*” in Schlossberg’s Transition Process Model (Schlossberg, 2011:160), as the SP-participants shared their perceptions about the feelings and emotional reactions of TSs in the event of an UP and/or TOP. Their perceived accounts provided insight into the students’ level of coping with these life challenges. Coping, and the inner strength and resilience of the individual are the facets of the Self in the Transition Process Model.

The research findings presented on the TS-participants’ feelings and emotional reactions, and the pressures and support needs emanating from their UP and/or TOP-experience, as presented in the previous chapter, correspond with the perceptions of the SP-participants, as the ensuing thematic discussion will demonstrate, underscored by storylines from these participants and verified by existing literature and research findings. The reader is therefore advised to read this section in conjunction with the mentioned section in Chapter Four (see Section 4.3.1.3, 4.3.2.3 & 4.3.3.3).

The data that emerged in relation to Theme Two resulted in this theme unfolding into the two sub-themes that will be presented next.

5.3.2.1 Sub-theme 2.1: SPs’ perceptions of the feelings and emotional reactions experienced by TSs presenting with UPs and/or TOPs

For a TS to be confronted with an UP and/or to experience a TOP is a stressful and traumatic life challenge, especially given the psychological, social, educational, economic, and medical consequences it presents (Mantell et al., 2015:1133; Van Breda, 2011:3; ‘Lanre, 2010:197).

The SPs’ perceptions of the feelings and emotional reactions experienced by TSs presenting with UPs and/or TOPs led me to present this sub-theme according to seven categories.

- a) Category 2.1.1: SPs perceive TSs as being pressured and experiencing feelings of confusion about the UP and the management thereof

The crisis in which an unmarried student confronted with an unintended pregnancy finds herself typically necessitates prompt decision making (Hall et al., 2017:1337; Adams & Williams, 2011:1881; Likis, 2009:2). This period spanning from the student realising that she is pregnant to the time when she has made the final decision to either carry the pregnancy to term or to terminate the pregnancy, is generally characterised by intense feelings of ambivalence (Kjelsvik & Gjengedal, 2011:169). How the UP will be managed and the decision-making process followed is determined and strongly influenced by the feelings of uncertainty and bewilderment experienced. Intertwined with this are the other realities, such as educational considerations, financial constraints, moral and/or religious concerns, as well as support or lack of support from partners, parents, family members, and friends (Nelson & O'Brien, 2012:507; Miller, 2011:73; Ekstrand et al., 2009:175).

In illuminating this category, the following SP accounts are presented:

“The pressure of having to make a decision; the feelings of not knowing what to do, what if the decision that she makes is the wrong decision [is overwhelming]” [Ed-Psych-4].

“The decision making [referring to how to manage the UP] is quite a stressful time for the student, and I think the experience... the pressure... and all the different emotions... is quite overwhelming” [SW-2].

“...I mean it's... [an] overwhelming thing... emotion... is confusion, what should her [referring to a student with an UP] decision regarding the pregnancy be? ...should she abort or not?” [VC-5].

“I find that our students really struggle with confusion in this regard... when they have to make a decision... they really don't know what to do” [C-Psych-1].

- b) Category 2.1.2: SPs perceive TSs to experience feelings of loneliness and lack of support

Feelings of loneliness and isolation, whether it is experienced upon the confirmation of an UP or as a result of the pregnancy outcome/decision, seem to accompany the myriad of confusing and conflicting feelings and pressures experienced by TSs confronted with an UP and/or TOP (Adams & Williams, 2011:189; Steck, 2011:31). The SP-participants' perceptions provided below elucidated the aspects of this category:

“But they [referring to TSs with UPs and/or TOPs] feel so alone – they will sit in your office talking about how alone they feel – like there is no one there for them, no one who understands what they are going through, no one to support them... and how sad that makes them feel” [VC-3].

“Often... the man... the boyfriend, the partner... often runs away... and leaves her with the crisis, so she's alone...” [HCP-1].

“...due to the fact that it's unplanned, obviously sometimes they don't even inform their parents or their partners, and then they withdraw from everybody – they isolate themselves [sic]. And then the other reason for isolating is the fact that they're trying to hide the pregnancy as well. So eventually isolation leads to depression” [Clin-Psych].

“...many times... their boyfriend is not there... so they don't have support. And their family is not supportive because... for example Christian families and other... African families, it's not acceptable to be pregnant...” [Ed-Psych-2]

Many students, as confirmed by the TS-participants of this study, prefer to keep their UP-status and/or TOP-procedure a secret, resulting in experiencing feelings of isolation. The fear of being judged, stigmatised, and blamed or even banished (Akbarzadeh et al., 2016:191) is the cause for this behaviour and has been mentioned as one of the barriers in utilising support services. The actual or perceived lack of understanding and support from partners, parents, friends, and

family members when dealing with any of these life challenges has also been cited as reasons for TSs' (increased) feelings of loneliness and withdrawal from significant others (Tabane & Mmapheko, 2015:2; Adams & Williams, 2011:1884; Steck, 2011:31).

The reference of the SP (Clin-Psych from Tertiary Institution A) to depression is confirmed by other scholars, who state that feelings of depression, sadness, and disappointment (whether it be in herself or a fear of disappointing others, such as her parents) are common emotional reactions experienced by students with UPs and/or TOPs (Barton et al., 2017; Adams & Williams, 2011:189; Van Breda, 2011:4; Arhin and Cormier, 2008:213; Sekgobela, 2008:90).

- c) Category 2.1.3: SPs perceive TSs as being afraid of the negative reactions of and abandonment by their significant others

The following excerpts from the SPs gave rise to this category and are provided in substantiation of it:

"Lots of fear. Fear of being rejected by parents, fear of letting them down... or being rejected by them" [Ed-Psych-3].

"The other experience that I think the students... go through is... many of them are blamed [for the occurrence of the UP] or rejected by their boyfriends after finding out that she's pregnant... the guy will just say 'Our relationship stops here'. So it's lot of rejection from the boyfriend – as if it was her fault" [HCP-1].

"And then there are the students who... will say – 'Well, how are they going to tell their parents [who] worked so hard to get them here?' So much effort has been put in and... they are just so afraid to tell their parents... 'My dad is going to kill me' or 'My mom is going to kill me.' I think that must be one of the... scariest things to have to do is tell your parents you're pregnant when it was expected of you to finish with your studies, go get a job..." [VC-9].

“...The fear to tell their parents... Because there are a lot of expectations, a lot of money invested in them, and very often they don’t want to tell their parents, and very often we have the situation that they actually continue with their pregnancy, hiding it from their parents, until it’s at a stage where it no longer can be hidden...” [C-Psych-2].

“...they [referring to students with UPs and/or TOPs] are so afraid to tell their parents... some of them are terrified of the scolding, rejection, or the withdrawal of support... financially or emotionally... they want you to almost act as a buffer... And soften the blow ...” [VC-10].

Negative comments, reactions, and/or rejection, whether these are based on religious, moral, or cultural factors, societal expectations, or the fact that financial investments were made that are now going to waste, are feared by young unmarried women experiencing an UP. The mentioned factors therefore contribute to and influence their decision on how they manage the UP (Tabane & Mmapheko, 2015:2; Van Breda, 2011:24; Adams & Williams, 2011:1881; Panday et al., 2009:27; Arhin & Cormier, 2008:214). The likelihood of unintended pregnancies and TOPs negatively impacting the quality of relationships with significant others is furthermore reiterated by several scholars who elaborate on the parents or the partner reacting with anger, panic, indifference, or rejection (Akbarzadeh et al., 2016:191; Adams & Williams, 2011:1882; Ekstrand et al., 2009:175–177; Naidoo & Kasiram, 2006:341).

- d) Category 2.1.4: SPs perceive TSs as experiencing feelings of guilt and shame

The TS-participants admit to experiencing feelings of guilt and shame as a result of an UP and/or TOP (see Section 4.3.1.3.4 – Category 1.3.4). The perceptions of the SP-participants about the feelings and emotional reactions experienced by TSs confronted with an UP and/or TOP below also speak to these feelings:

“...so there’s so much... guilt... guilt for yourself... ‘how could I let this happen?’ ...guilt towards others, the parents... like ‘I must, I must achieve something...

because my parents are paying for this' [referring to tertiary education] ... 'I owe it to them and to myself'..." [Ed-Psych-1].

"...they feel very guilty, and... not good about themselves, so when they have high moral values it's even worse..." [VC-8].

"I think there's a lot of shame and a lot of stigma... these young women are not talking to their friends about it [referring to the occurrence of an UP or TOP] – it's a deep, shameful secret..." [SW-2].

The perception amongst TSs' dealing with unintended pregnancies or TOPs that they are disappointing, embarrassing, or dishonouring their significant others (by not meeting the educational standards that were set for them or that they are promiscuous or immoral) (Akbarzadeh et al., 2016:191) resulting in, inter alia, experiencing feelings of guilt and shame, resonates with the above-mentioned perceptions of the SPs. Amid the myriad of feelings experienced by TSs with UPs and/or TOPs (such as resentment, uncertainty, loneliness, depression, regret, loss of self-confidence, anxiety, and post-traumatic stress), the impact of guilt and shame seem to be of particular significance with several authors describing it as intense and overwhelming (Adams & Williams, 2011:1879; Kjelsvik & Gjengedal, 2011:172; Wilks & Spivey, 2010:277; Ekstrand et al., 2009:175).

- e) Category 2.1.5: SPs perceive TSs as experiencing feelings of shock upon the confirmation of the suspicion of an UP

Adams and Williams (2011:1880) purport that the confirmation of the suspicion of an UP amongst TSs is generally perceived as a "shocking experience" and even "highly traumatic" (Akbarzadeh et al., 2016:190). The feelings of shock, denial, and disbelief experienced by TSs upon the confirmation of an UP are also echoed in the responses of the of the SP-participants below:

"And when the student finds out... when it is confirmed that she's pregnant her first reaction is usually shock... and denial..." [HCP-2].

“...a lot of the students... they’re so shocked then when it does happen...” [SW-1]

“The first thing that I’ve seen with the students is the shock, like a disbelief... they just can’t believe that they actually fell pregnant... yes, despite not using contraception... the realisation normally comes as a huge shock... and then they just want a quick solution to the problem... they want to be ‘un-pregnant’ again...” [VC-4].

Worry and concern about the impact of the UP on their academic objectives, and financial and everyday circumstances normally accompanies the feelings of shock and for most students in a crisis pregnancy, TOP initially seems to be the easiest way to deal with the problem (Adams & Williams, 2011:1880; Steck, 2011:18; Abiodun & Balogun, 2009:146). Thus, these initial feelings of shock and fear might prompt a student to make an impulsive decision, without careful consideration and/or guidance regarding the possible consequences thereof (Ekstrand et al., 2009:173). The opportunity provided by a TOP to quickly and secretly become “un-pregnant” can become an alluring option, especially when feeling overwhelmed, shocked, and traumatised by the confirmation of an UP (Macleod & Tracey, 2009:12; Badenhorst, 2005:85).

f) Category 2.1.6: SPs perceive TSs as experiencing trauma as a result of the TOP-procedure

The termination of a pregnancy, despite it being unwanted or unintended, is labelled by Steck (2011:18) as a “uniquely traumatic experience” and its effects are physically, emotionally, and psychologically significantly prevalent with side effects ranging from mild regret to serious depression (Frederico et al., 2018:335; Steck, 2011:16; Ekstrand et al., 2009:177; Major et al., 2009:863):

In underscoring the SPs’ perceptions about students experiencing the TOP-procedure as traumatic, the following accounts are provided:

“They [referring to TSs who have experienced a TOP] are usually very traumatised... they are so traumatised they cannot even... concentrate on their

studies... like with their studies... they can't focus, they become depressed... Their studies then become a problem, because if you don't send them to [referring to student counselling services] they come back later on during the year not knowing where they are going, because they lack in their studies because of the trauma..." [HCP-1].

"...it's very traumatic for her to experience the procedure [TOP]; the bleeding, the witnessing of the whole procedure... it's painful. They experience post-traumatic stress... and many express regret about going for the procedure..." [VC-6].

"I have been seeing a student now for almost three months for post-traumatic stress counselling... as a result of the TOP that she went for last year..." [C-Psych-2].

Experiencing symptoms of post-traumatic stress following the TOP is not uncommon (Frederico et al., 2018:335; Steck, 2011:16; Ekstrand et al., 2009:175; Patel & Kooverjee, 2009:562), with the following emotional and behavioural manifestations being displayed: tearfulness; indecision; disturbed sleep, irregular sleeping patterns and nightmares; flashbacks; inappropriate anger outbursts; self-punishment; painful thoughts and feelings on significant dates; isolation; suicidal ideation and suicide; avoidance of babies, children and pregnant women; relationship problems and withdrawal; promiscuity; and/or sexual coldness and avoidance of intimacy (Frederico et al., 2018:335; Kjelsvik & Gjengedal, 2011:174; Steck, 2011:18; Ekstrand et al., 2009:177; Oosthuysen & Mfomande, 2008:25).

The SPs also perceived the TSs with UPs and TOPs to experience academic and financial-related pressures, aspects highlighted by the TS-participants themselves (see Section 4.3.1.4 and 4.3.2.2). As mentioned earlier in this Chapter, these pressures could force students to go the route of a TOP, to regain normality and to continue with their educational aspirations (Valois et al., 2013:37). It is once again recommended that this discussion be read in conjunction with the feedback received from the participating TSs (see Section 4.3.1.4 and 4.3.2.2).

- g) Category 2.1.7: SPs perceive TSs as experiencing academic and financial pressure and stress

TSs are unprepared to deal with the eventualities of an UP or a TOP, as they lack the essential, appropriate coping and interpersonal skills required for the effective management of such crises (Tabane & Mmapheko, 2015:5; Daley, 2012:39). Absence of practical and/or emotional support, as elaborated upon earlier in this research report, could result in these pressures being perceived as overwhelming (Barton et al., 2017; Tabane & Mmapheko, 2015:5; Adams & Williams, 2011:1881; Patel & Kooverjee, 2009:559; Skinner et al., 2009:53 Ekstrand et al., 2009:177; Philkill & Walsh, 2002:21).

In elucidating this category, the following accounts from SPs are presented:

“Well, our students definitely... has huge obstacles to overcome academically because [when] she gets pregnant, [its]... fine through the early stages of pregnancy... but then those last few months, [when] pregnancy takes its toll... and you get tired and miss class. Then you have to go and have the baby and in that process you miss out on class... I think a lot of them [referring to TSs with UPs] ...try to come back as soon as they can... Or, if they do decide ‘I’m going to take a month... or two months off’, to come back and then to catch up... its hectic and sometimes they can’t and I think sometimes they just drop out... [or] I think they... are unable to catch up, they end up repeating...” [SW-1].

“...some students... drop out because of abortion... the TOP takes its toll... Their marks go down. Immediately after finding out that they are pregnant their performance level goes down, because the person is under pressure. Yeah, it’s like most other problems... [Your] concentration is short... and... your academic performance is affected... they experience a lot of stress in this regard” [VC-7].

The participant accounts presented are confirmed by the literature consulted, which states that the experience of being a young, pregnant student has the potential to place a student under great pressure and stress, which might leave her feeling that she is unable to cope with and/or meet the severe and compelling

academic demands being placed on her (Valois et al., 2013:38; 'Lanre, 2010:197; Arhin & Cormier, 2008:213). The academic pressures together with the stress caused by the UP seem to distract, delay, or derail students from reaching their educational goals. In addition, the perceived lack of faculty and/or institutional support seems to add to the academic pressures experienced, further increasing the risk of dropping out (Valois et al., 2013:37, 38; Miller, 2011:69; Skinner et al., 2009:52; Arhin & Cormier, 2008:213, 215; Naidoo & Kasiram, 2006:344).

When turning to the aspect of financial pressures and stress, the dire financial situation that many TSs find themselves in has been described as a major psychosocial challenge (Van Breda, 2011:4). When adding to this mix the eventuality of an UP it contributes to and increases these TSs' financial vulnerability and anguish (Akbarzadeh et al., 2016:511; Valois et al., 2013:50). The following storylines testify to the financial pressures and stress experienced by students with an UP, as shared from the SPs' perspectives:

"I often find that the parents of the tertiary student confronted with an unplanned pregnancy will say 'Okay, we're not going to support you financially anymore. Now you have to look after your own child. You can't study and look after the child'. There's no financial support... and I think that's a big, big, big problem ...Also [if] the financial support is a bursary or study loan... Many of our students are studying with bursaries or loans... because their parents can't afford to pay for the studies... and then the other... scenario is... a student will be in her final year, for instance, and realise 'I can't parent this child [now], I have to complete my studies' ...We see many clients that come from very disadvantaged backgrounds where there is no support system... just no money or the support system is far away and financially they, even if they want to, they can't help. So, finances play a major... has major influence on the decision that the student has to make" [C-Psych-4].

"To me their concern is... financial – 'How will I be able to look after this child?'" [VC-2].

“What I’ve experienced is that they don’t want to involve their parents, they keep quiet, so you’ll find that... if they consider TOP, they don’t have money to pay for TOP” [HPC-1].

“I also found... students who are ... using the children’s grants to survive here [referring to life at university]. At least they are getting the money... the grant money gets paid directly into the student’s account. I am not sure if that is why they get pregnant, some of the young girls are so desperate for money” [VC-5].

The financial stress experienced by TSs with an UP is attributed to the threat of or the actual withdrawal of financial support from parents, because many of them are unemployed and they simply cannot carry the burden of supporting another child, especially since they already had to make significant sacrifices to keep their daughter at university. Financial stress may also be attributed to the partner, who might also be unemployed or still studying, or a study loan/bursary being revoked or withdrawn because of disrupted studies (Barton et al., 2017; Levi et al., 2009:303; Arhin & Cormier, 2008:214; Ratlabala et al., 2007:29).

Of particular interest in this regard was the utterance by VC-5 about the possible association between the CSG and the occurrence of youth/adolescent pregnancy. Several studies, highlighting national and international debates and controversy surrounding the possible connection between adolescent fertility and the social welfare benefits system, have been conducted in an attempt to establish whether young women are deliberately having children in order to access the fiscal benefits offered by most democratic countries’ welfare systems (Makiwane, 2010:194; Pettifor et al., 2005:1528; Case, Hosegood & Lund, 2004:479). The conclusion of Makiwane, Desmond, Richter and Udjo (2006:5) and Jordan, Patel and Hochfeld (2014:393) about this issue was that they found no evidence to support the claim that grants influence youth/adolescent pregnancy or the claim that an association exists between adolescent fertility in South Africa and the CSG (Makiwane, 2010:194; Makiwane et al., 2006:14). The mentioned authors did however recommend specifically designed studies to further address and investigate this issue more conclusively.

The presentation of the SP-participants' perceptions of the feelings and emotional reactions experienced by TSs presenting with UPs and/or TOPs is herewith concluded. The focus of the discussion will now shift to their perceptions of the support needs of TSs presenting with an UP and/or a TOP.

5.3.2.2 Sub-theme 2.2: SPs' perceptions of the support needs of TSs presenting with UPs and/or TOPs

The SPs' perceptions of the support needs of the said students (presented next under three categories) link closely with the suggestions offered by the TS-participants for support to students presenting with an UP and/or TOP. It is therefore recommended that this discussion be read in conjunction with these suggestions mentioned in Chapter Four (see Section 4.3.4).

- a) Category 2.2.1: SPs perceive TSs presenting with UPs and TOPs to be in need of counselling and support

From the SP-participants' accounts below it became clear that counselling and support should be of a practical nature, focusing on the provision of psychosocial support, information on the options to manage and deal with an UP, what the different options entail, as well as stress management, financial management, and relationship issues.

"I... it's actually a shock for me if a pregnant student makes an appointment for counselling... and I discover how little they really know... the majority of them have so little information... they need to be informed because they don't know what a TOP really entails, where to go for the procedure. They don't know what parenthood entails... if she decides to continue with the pregnancy, chooses parenthood... the practical implications... where will she... they live... if she is a residence student she will not be able to stay in the residence. And how to take care of a baby, how this all will impact on her relationships, her finances, her studies" [SW-1].

“...and they need time to really investigate the [UP] options, make an informed decision, a counsellor to give them all the information, to support them through the process...” [C-Psych-3].

“...support during and after the pregnancy or TOP, and practical advice, like where to find suitable, safe accommodation, even things such as maternity wear, you know, practical advice, referral to resources who can assist with these challenges” [VC-2].

“...and the need just to have someone to talk to, someone who won’t judge them because they are pregnant or had an abortion, someone to help them deal with the stress and worry... a lot of emotional support” [C-Psych-4].

The SPs’ perceptions of TSs’ needs regarding counselling and support is confirmed by several authors (Kjelsvik & Gjengedal, 2011:172; Miller, 2011:69; Steck, 2011:18-19; Aujoulat et al., 2010:45; Ekstrand et al., 2009:178) purporting that the counselling support should be practical, and the advice and information being provided should be accurate and comprehensive. This is important so as to enable students to make a calculated decision on how to manage their UP. With regard to provision of emotional support, the SP should be non-judgemental. Confronting any possible myths and/or cultural/traditional, religious or moral beliefs held by the student, which could have a negative effect on the decision-making process regarding the UP, should be done in a sensitive and empathic manner.

Furthermore, and in the context of providing counselling and support to women who are confronted with and have to deal with an UP and/or a TOP a psycho-educational approach is suggested by several scholars (Adams & Williams, 2011:1881; Corkin, 2011:3; Kjelsvik & Gjengedal, 2011:174; Van Breda, 2011:6; Aujoulat et al., 2010:451; Rosen, 2010:8). The focus of the psycho-educational counselling endeavours should be on the aspects of:

- providing relationship advice, guidance and support, specifically on issues of communication, respect, and trust in establishing and maintaining healthy relationships with significant others;

- stress management, focusing on the provision of advice on how to manage stress and constructive coping skills;
 - loss and bereavement counselling and how to express and manage the feelings and emotional reactions emanating from the traumatic experience resulting from a TOP; and
 - financial management skills and practical advice on budgeting, the possibility of pursuing part-time employment, and linking students to facilities and resources offering grants/study loans.
- b) Category 2.2.2: SPs perceive TSs presenting with UPs and/or TOPs to be in need of on-campus medical support

The SPs' perceptions about the TSs presenting with UPs and/or TOPs needing on-campus medical support correlate with the same view held by the TS-participants (see Section 4.3.4.1). The storylines below are given in substantiation of this category:

"On our campus... we don't offer... pre-natal care here, but this is what the students need" [HCP-2].

"...medical assistance... complete medical information, support and assistance, like a baby clinic, to be available to the students, on campus... that is what they need" [VC-8].

"Most of our students don't have medical aid, that's when... it becomes difficult for them. ...we need to look at offering them better medical support and assistance... here on campus, and the referral systems to outside resources needs to be improved" [Ed-Psych-4].

"If the student wants to terminate the pregnancy... we have to refer them to outside clinics – this is what is available. There is this attitude of 'We are a tertiary institution, we are not a hospital'" [C-Psych-4].

As mentioned earlier in this research report (see Section 4.3.3.1), medical support on campus available to assist TSs presenting with UPs and/or TOPs generally seems to be limited to pregnancy diagnostics and providing information about UPs and STIs (mainly on how to prevent this); assessment of general health/wellbeing; the identification and treatment of basic health problems, such as heartburn and nausea; the provision of basic pregnancy supplements, such as folic acid and vitamins; and, in some cases, provision of emergency contraception. Students needing other specialised forms of pregnancy-related support or intervention, such as treatment for hypertension or diabetes, ultrasounds, and pre-and post-natal care, or TOP-procedures and treatment for TOP-related complications, are normally referred to private healthcare practitioners or community/government healthcare facilities (Baird & Porter, 2011:154; Burgen, 2010:23).

The perceptions of the SPs, pointing to the need of TSs with an UP and/or TOP needing on-campus medical support, highlights the non-utilisation of such services in the community due to inaccessibility and/or not having the money and/or transport fees to get to these services. Having on-campus medical support available could result in improved utilisation of the appropriate healthcare service required by said client system group (French et al., 2017:716; Baird & Porter, 2011:156; Burgen, 2010:23; Levi et al., 2009:312).

- c) Category 2.2.3: SPs perceive TSs presenting with UPs and/or TOPs to be in need of academic support

The SPs' accounts (below) are illustrative of some of the trials and tribulations encountered by TSs with an UP and/or TOP in trying to keep up with academic demands. The accounts also contain suggestions for academic support to these students.

“Although some lecturers are supportive and understanding, I have heard of lecturers who are just not accommodating at all. If a pregnant student misses a test, they are rude. One of the students that I was seeing for counselling while she was pregnant told me that a lecturer told her: ‘I’m not running a maternity ward here. Go and give birth, come back when you are okay’” [C-Psych-2].

“...They need a lot of support – academic support... if they struggle to keep up with the demands, maybe some extra assistance and understanding...” [HCP-1].

“...in ... those last few weeks of pregnancy... [they should be] allowed to hand in assignments late, write a sick test, be... allowed to take the time needed post-birth. That they do need” [VC-9].

“I think there should be specific programmes to support them academically” [Ed-Psych-4].

“More support from the academic institution, you know... pregnant students have to leave the residence, they can’t stay in the residence until the end of their pregnancies... some of them then have nowhere to go...” [VC-10].

Literature confirms the notion that some lecturers and/or academic staff seem to be oblivious to the challenges experienced by students as a result of an UP or a TOP, as well as these students being afraid to be judged and discriminated against which could result in them feeling uncomfortable in approaching their lecturers for support in terms of managing their academic responsibilities whilst dealing with the crisis or trauma (Mbelle et al., 2018:515; Van Breda, 2011:24; Pugh, AN, 2010:23; SmithBattle, 2007:368).

In summary of this sub-theme, the SPs’ perceptions (which in some instances were coupled with suggestions) of the support needs of TSs confronted with an UP and/or a TOP, confirmed by the literature consulted, underscore the value and significance of institutional/academic support programmes aiming to address the counselling, medical, and educational needs of this client system group which could mean the difference between academic failure or success (Mbelle et al., 2018:515; Burgen, 2010:29; Arhin & Cormier, 2008:215; Sadler, Swartz, Ryan-Krause, Seitz, Meadows-Olivier, Grey & Clemmens, 2007:128).

Presentation of the research findings related to the theme on the SP-participants’ perceptions of the experiences and support needs of TSs in relation to their UPs and/or TOPs is herewith concluded. The next theme will consist of a discussion of

the scopes of the support services offered by the SP-participants to TSs presenting with UPs and TOPs.

5.3.3 Theme Three: The scopes of the support services offered by SPs to TSs presenting with UPs and/or TOPs

In attempting to gather information about the scopes of the support services offered by SPs to TSs presenting with UPs and/or TOPs, I posed the following question to them: *“What are the scopes of the support services that you offer to TSs presenting with UPs and/or TOPs?”*

Their responses to this question are to be presented under two sub-themes, with the first sub-theme branching into three categories.

This theme fits in with the aspect of *“Support”* in Schlossberg’s (1981:11) Transition Process Model, and specifically “institutional support” with reference to the service departments within the tertiary institutions, as well as the health and welfare institutions in the community that these students could approach for assistance and support. It is purported that an individual’s ability to adapt to and integrate transitions is closely linked to the person’s environment, with the latter encompassing interpersonal and institutional support systems available, as well as the physical setting (Schlossberg, 1981:10).

5.3.3.1 Sub-theme 3.1: SPs offer counselling as support service to TSs presenting with UPs and/or TOPs

With reference to providing counselling as support service, the SPs made reference to crisis pregnancy counselling, post-abortion counselling, and bereavement counselling; referring students to other SPs; liaising with and counselling significant others; as well as the provision of life skills and psycho-education. These aspects will be presented next as categories.

- a) Category 3.1.1: The provision of crisis pregnancy counselling, post-abortion counselling, and bereavement counselling

In illuminating this category, the following storylines are provided:

“And here [referring to the CPCC], we do crisis pregnancy counselling, we help the girls to make an informed decision and tell them about the different options... we support them through their decision-making-process... we also do post-abortion stress counselling” [VC-3].

“... they [referring to TSs with UPs and/or TOPs] come to you when there’s a crisis... when either the UP affected their studies or if there’s a problem with the lecturer or if the boyfriend suddenly rejected or left them... pregnancy mostly comes with crisis with our students... and then it’s crisis intervention and stuff that has to happen fast... because it’s been left for too long or an abortion decision has to be made this week because if it’s... next week it’s too late” [C-Psych-4].

“We have psychologists... [and] the social workers here offer individual supportive counselling sessions... we offer therapeutic and emotional support... and we do a lot of crisis intervention and also post crisis counselling” [SW-1].

“...we do the PAS [referring to post-abortion stress counselling] and we do a lot of loss and bereavement counselling as well” [Clin-Psych].

“And if the [pregnancy] test is negative we... use that opportunity to have a discussion with the student... we tell her about STDs and ...we sometimes recommend that she continues with counselling, especially if we see that there might be underlying problems, like relationship problems” [HCP-2].

The importance of recognising and utilising the “window of opportunity” (Levi et al., 2009:306; Likis, 2009:2) resulting from an incident such as a negative pregnancy test, as articulated by HCP-2 above, is emphasised by several authors who state that therapeutic support and/or intervention for TSs with UPs and/or TOPs should not only include contraceptive counselling, crisis pregnancy counselling (with

specific reference to the available options), pre- and/or post-abortion counselling, and relationship counselling, but it should also aim to deal with other possible/underlying concerns emanating from a negative pregnancy test result. This state of affairs could provide an opportunity to explore the likelihood of high-risk sexual behaviour and offer appropriate and timely guidance, support and intervention in this regard (Kjelsvik & Gjengedal, 2011:174; Van Breda, 2011:21; Burgen, 2010:32). In doing so, the essential goals of UP- and TOP-counselling support could be achieved. These are: the empowerment of women as partners in healthcare, advocacy for informed choice, the right to self-determination, and skilful communication (Rose, Cooper, Baker & Lawton, 2011:1734; Likis, 2009:1; Arhin & Cormier, 2008:214).

The provision of crisis pregnancy counselling, post-abortion counselling, and bereavement counselling denotes providing confidential and professional support in terms of providing accurate information in a non-judgemental and emphatic fashion (Kjelsvik & Gjengedal, 2011:172; Burgen, 2010:24; Martin & Oswin, 2010:59; Ekstrand et al., 2009:179).

Closely related to this aspect of counselling support is the aspect of the timely and appropriate referral of TSs dealing with the mentioned life challenges to other internal and external resources, and liaising with them as well as with the student's significant others.

- b) Category 3.1.2: Referral to and liaison with internal and external resources and the student's significant others

The SPs indicated that another component forming part of their scopes of service delivery is to assist the student presenting with an UP in terms of informing her significant others about the state of affairs.

“So... a pregnant student would sit in my office and say, ‘Okay, there is an uncle that I need to tell that I’m pregnant now and I don’t know how to do it’ and, in that case I would say to her, to the student, ‘Can I phone your uncle? Do you want me to speak to him first?’” [C-Psych-4].

“...student support, by call[ing] the parents and say[ing], ‘Please come’ because when the social worker phones and say, ‘You know what, there’s a problem with your child, won’t you just please come in?’ ... [they do]. Then I would be there with the parents when we tell them that... their daughter is pregnant” [SW-1].

“And then... we usually [as part of] our services, we... call in parents... or family, or the boyfriend to say – ‘Come to our offices... and let us have a discussion’” [Ed-Psych-4].

Informing and eliciting the support of the significant others regarding the TS’s UP and/or TOP has been found to play a mitigating role in reducing feelings of ambivalence, fear, anxiety, and loneliness experienced by many students confronted with these life challenges. It furthermore assists with the decision-making process (Kjelsvik & Gjengedal, 2011:172; Van Breda, 2011:20; Aujoulat et al., 2010:451). The convoy of support made up of significant others (Khan, in Schlosberg, 1981:10) has a moderating effect on the personal and academic stress experienced as a result of the UP (Kjelsvik & Gjengedal, 2011:172; Van Breda, 2011:20; Aujoulat et al., 2010:451; Wilks & Spivey, 2010: 286; Ekstrand et al., 2009:177; Wilks, 2008:120).

With reference to the aspect of referring students with UPs and/or TOPs to internal resources within the university and external sources in practice, the following supporting storylines are provided:

“But if she [referring to a pregnant student] has chosen adoption or foster care... then we [referring to SPs at Tertiary Institution A] have a referral system... we refer her to a social worker that specialises in adoption and foster care... and that social worker then walks that road with her” [C-Psych-3].

“We refer... where necessary... We have resources, and information about a range of different services in the community, referral lists for adoption, for advice... places, clinics they can go to for TOP, depending on what stage they’re at, and how much they can afford [to pay]. We’ve networked with one specific clinic. We met with the nurse there and she seemed quite approachable, it’s nice and it’s

generally more for affluent students, but we have established a relationship with her... that if a student can't afford the TOP, they actually help our students for free" [VC-9].

"...And then naturally the hospitals where they [referring to pregnant students] actually give birth... if the student has a medical aid, she can go to a private hospital otherwise we refer her to one of the government hospitals" [SW-2].

"...most of the students who need a TOP, because we don't do terminations at the clinic here [referring to the campus healthcare facility], we refer them out. So most of the students, because of a lack of financial support or medical aids, we refer them to the [community] clinic" [HCP-2].

"And we refer to interdepartmental services, for example from student counselling to student health... the campus clinic and vice versa... or to study counselling. Sometimes the student might need some study counselling, then we refer her to the relevant people... also to the academic department to assist with logistics to support them with their studies, we liaise with their lecturers, their academic departments if necessary" [SW-1].

As mentioned by the participants, tertiary institutions do not provide TOP-procedures, adoption services, or foster care services. Such services are offered by healthcare professionals and social workers duly qualified and registered to render such services (Van Breda, 2011: 26; Martin & Oswin, 2010:59; Rosen, 2010:17; Naidoo & Kasiram, 2006:350). As was mentioned, the SPs refer students for these specialised services and advocate for such services to be rendered to students. This underscores the importance of SPs having an efficient and comprehensive contact/resource list available when assisting TSs with UPs or TOPs (Kjelsvik & Gjengedal, 2011:174; Van Breda, 2011:21; Wilks & Spivey, 2010:283; Ekstrand et al., 2009:178).

The aspect of establishing and maintaining good relationships with fellow professionals and organisations/resources provides a convoy of support of fellow-colleagues and SPs in the community (as external sources of support), and fellow

colleagues, service departments, and lecturing staff services (as internal sources of support) to refer students to will assist them with the many challenges associated with an unintended pregnancy or TOP (Kjelsvik & Gjengedal, 2011:174; Van Breda, 2011:8; Wilks & Spivey, 2010:283; Martin & Oswin, 2010:59; Arhin & Cormier, 2008: 215).

c) Category 3.1.3: Life skills and psycho-education

Prior to presenting the storylines to substantiate this category of life skills and psycho-education, an exploration of the concepts “life skills” and “psycho-education” was deemed appropriate and I therefore wish to briefly elaborate on these concepts in the ensuing discussion.

The WHO (1999) defines life skills as “abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life”. Furthermore, three categories of life-skills are mentioned. These are: reflective skills, such as problem-solving and critical thinking; personal skills, such as self-awareness; and interpersonal skills for communicating and interacting effectively with others. Execution of life skills in a positive fashion fosters self-esteem, sociability, and tolerance, enabling an individual to competently take action, generate change, and have freedom of choice (Adams & Williams, 2011:1881; Ekstrand et al., 2009:177).

Life skills education, in the context of tertiary education, can be presented according to a structured programme format. Such a programme should be needs and outcomes-based, encouraging participatory learning aiming to increase positive and adaptive behaviour, assisting individuals to develop and practice psychosocial skills that will minimise risk factors and maximise protective factors (Haberland & Rogow, 2015:18; Yankey & Biswas, 2012:514).

Psycho-education refers to education and training offered to students which enables them to address and solve current or potential psychological and social challenges or problems encountered within social contexts (*Merriam-Webster Online Dictionary*, n.d., sv “Psycho-education”). As such, psychosocial support

and/or intervention are integral to psycho-education. Psycho-education aims to inform, educate, and empower; create understanding and awareness; and establish a sense of commitment/responsibility toward one's own health and wellbeing (Yankey & Biswas, 2012:514).

The following storylines of the participants attest to life skills training and psycho-education as part of their counselling support offered to TSs with UPs and/or TOPs:

"In terms of being proactive... we... collaborate with Campus Health Services [referring to the campus clinic] ...we distribute information regarding psychosocial problems, we facilitate campaigns with them in this regard to inform students about condom usage... contraceptives, amongst others" [C-Psych-1].

"And we also have... [the life skills programme] ...which empowers them to... deal with [practical, present, and future day-to-day challenges]. It's [a few sessions that] stretches over a few weeks... [it includes] ...the 14 relationship components, some parental skills, self-esteem, the temperament, decision-making skills, problem solving skills, communication, conflict..." [SW-1].

"...here at campus health, we do contraceptive services... we work with the student counsellors and we go to the residences, educate especially the first year students about contraceptives, family planning, about looking after themselves... they come to the clinic, we have orientation programmes at the clinic, and we go to the faculties. We go there and educate them" [HCP-2].

"Okay, our services in this regard... basically its health promotion – we promote health with the aim of preventing unwanted pregnancy. We're promoting the ABC of abstinence and condom – being faithful... condomising, and also the use of contraceptives" [HCP-1].

The underlying preventative aim noticed in the SPs' life skill and psycho-educational endeavours finds support in the literature, which accentuates the promotion of contraception and/or abstinence to prevent UPs and the resultant

TOPs (Adams & Williams, 2011:1881; Baird & Porter, 2011:155; Rosen, 2010:18; Ekstrand et al., 2009:177).

In addition to offering counselling and support to TSs with UPs and/or TOPs, the SP-participants indicated offering medical support to this cohort of students. This is presented in the next sub-theme.

5.3.3.2 *Sub-theme 3.2: SPs offer medical support to TSs presenting with UPs and/or TOPs*

Contraceptives and/or family planning services; pregnancy testing; information on and education in sexual health matters focusing on topics such as HIV and STDs; and information regarding the options for managing an UP are provided by all the campus health services/clinics of the participating tertiary institutions and the CPCC, as deduced from the participants' accounts below.

“Here at the centre [referring to the participating CPCC] we do pregnancy tests free of charge. And we also share information about unplanned pregnancy, STIs, we discuss contraception with the students... we refer them to government clinics if they need testing or treatment for STIs” [VC-4].

“We [referring to the healthcare professionals at the participating tertiary Institutions] do pregnancy tests, we also test for HIV and STIs, and our students don't have to pay for it... we also give them condoms” [HCP-1].

“We treat sexually transmitted infections... and we link that with UPs, HIV, because now they don't use condoms, then they come in... the STIs – then when a student come to the clinic for STIs then you get a good platform of teaching her about HIV, about family planning, and encouraging her, motivate her to take contraceptives in the... method” [HCP-2].

The offering of the medical services for and support to the students alluded to by the SPs correspond with the accounts of the TS-participants related to this aspect (see Section 4.3.3.1).

The presentation of the scopes of the support services offered by the SP-participants to TSs presenting with UPs and/or TOPs is herewith concluded. In responding to the question, “*What are the scopes of the support services that you offer to TSs presenting with UPs and/or TOPs?*” the SPs spontaneously spoke about the resources they have available, as well as the obstacles encountered in offering support services to TSs presenting with UPs and/or TOPs. This led to the emergence of the following theme.

5.3.4 Theme Four: SPs accounts of the resources available and obstacles encountered in rendering support services to TSs presenting with UPs and/or TOP

This theme is divided into two sub-themes. The first sub-theme focuses on the resources available, and the second on the obstacles encountered in rendering support services to said group of students.

This theme ties in with the aspect of “*Institutional Support*” in Schlossberg’s (1981:11) Transition Process Model, but the focus is on the factors inherent in this type of support that help and/or hinder the SPs in their service delivery to students presenting with an UP and/or a TOP.

5.3.4.1 Sub-theme 4.1: Resources available to assist SPs in their service delivery to TSs presenting with UPs and/or TOPs

The resources available to assist the SPs in their service delivery are exemplified in the categories that follow below.

a) Category 4.1.1: Peer/collegial support as a resource

The rendering of support to TSs with UPs and/or TOPs is seldom offered in isolation, as students are referred to both service departments within the University, as well as service organisations in the community. The participating SP-participants formed part of multi-disciplinary teams or peer groups. The accounts below underscore the value of, as well as the support and guidance

received from their peers or fellow colleagues in this regard. This collegiality, characterised by a certain level of closeness and mutual trust, and respect for each other's experience and professional ability, together with the debriefing and supervision they receive from fellow-colleagues, are resources favouring service delivery.

“So we’re a wonderfully strong group [implying collegial support] and the support is here and there’s a unity here that’s quite nice... we share concerns, ask each other for advice, sometimes just debrief when we had a difficult session or day...” [Ed-Psych-2].

“...and here [referring to the participating CPCC] ...there is lots of sharing of information... which actually broadens all of our counselling methods...” [VC-6].

“Our senior staff... they are there for guidance, peer support, and supervision. We also have weekly meetings... group supervision, talk about challenging cases” [C-Psych-3].

“And I think in our... team of volunteers there’s lots of expertise and experience – life experience as well... so many of the volunteers bring their... own life experiences into the picture which money can’t buy and I think that’s special... It’s a huge resource, very big” [VC-7].

The storylines of the SPs coincide with the finding of Collins et al. (2010:973) who accentuate the significance of peer/collegial support, specifically for those in the helping professions. O’Connor and Cordova (2010:364) highlight the value of peer support as beneficial for continued growth and learning, while Zastrow (2010:197) found that cooperation and support within a group or team has the potential to positively impact on “accomplishment, helping and sharing, interpersonal skills and cooperative attitudes and values”.

b) Category 4.1.2: Specialised and on-going training as resource

The responses from the volunteer counsellors, specifically, gave rise to this category. They experienced the specialised and on-going training that they receive as positive and highlighted this as a resource with regard to service delivery to TSs presenting with UPs and/or TOPs.

“I think the best resource that we have here [referring to the CPCC] is the training that we get. It’s one of the best training courses I’ve ever attended. It’s so helpful because the tools... the training... how to communicate, how to do the steps” [VC-2].

“And it [referring to the training at the CPCC] is on-going, there are different... levels of specialisation...” [VC-8].

“... a very, very good training programme... it is practical and gives guidance, steps on how to deal with the crisis...” [VC-10].

The aim of counselling and support provided by CPCCs, as elaborated upon earlier in this research report (see Section 1.2), is to specifically address the unique experiences and needs of women confronted with, amongst others, crisis pregnancies by means of specialised care and intervention (Wiebe, Littman, Kaczorowski & Moshier, 2014:226). These centres are normally staffed by trained, supervised volunteer counsellors who offer the following free and confidential services: pregnancy tests; crisis pregnancy counselling at the centre or via telephone; comprehensive information on parenting, adoption, termination of pregnancy, the development of a baby and STIs; practical assistance in the form of affordable baby clothing, equipment, and necessities; applicable and relevant referral in the case of adoption or TOP; and counselling for pregnancy loss through TOP, miscarriage, or stillbirth (Wiebe et al., 2014:226).

As mentioned earlier in this chapter, all volunteer counsellors furthermore, regardless of their educational training, background, or profession, have to complete a specialised training programme widely used by pregnancy care

centres worldwide, namely *“Equipped to serve”* (see Footnote 13). The volunteer counsellors who wish to specialise in post-abortion stress counselling have to complete another training programme, referred to as *“The Journey: A road to post-abortion recovery”* (see Footnote 14).

Acknowledging crisis pregnancy and TOP counselling and support as a specialised field of service delivery and ensuring that the format and content of this resource is characterised by adequate, appropriate, tailor-made elements, are recommended by several scholars (Baird & Porter, 2011:156; Burgen, 2010:23; Levi et al., 2009:312). Empowering SPs with specialist knowledge, information, and training in this regard and encouraging continued professional development⁴⁵ is also strongly recommended, as these avenues improve the efficacy of service delivery to those rendered vulnerable as a result of experiencing a life challenge such as an UP or TOP (Van Breda, 2011:26).

- c) Category 4.1.3: Being located in the right spot and having private offices available as a resource for service delivery

Offering assistance, support, and counselling to TSs with UPs and/or TOPs in an office environment perceived by them as safe, easily accessible, private, reassuring, and non-judgemental is quintessential for confidential crisis pregnancy and TOP-counselling (Baird & Porter, 2011:156; Bafana, 2010:10; Levi et al., 2009:312).

In substantiating this category, the accounts of the volunteer counsellors which gave rise to it are provided:

⁴⁵ Although none of the SPs from the participating tertiary institutions made any reference to training targeted specifically at service delivery to TSs with UPs and/or TOPs, it is noted and affirmed that service delivery in this regard forms part of the general caseload of these practitioners and that the sole focus of their service delivery to TSs is seldom *only* on UPs and/or TOPs. They address a wide range of psychosocial problems causing psychological distress amongst students, of which the phenomenon of UPs and TOPs is but one (Reavley, McCann, Cvetkovski & Jorm, 2014:1659). Furthermore, continued professional development (for example, attending specialised training workshops on specific therapeutic or health related topics) is a pre-requisite for SPs (social workers, psychologists, healthcare professionals, etc.) in order to maintain their professional registration.

“The house that we use for our counselling... We’ve got a good house where we can counsel from... it is homely... but also professional. We have offices that are private; it is accessible to the students” [VC-5].

“...yes, it is on the bus route... I think the location is perfect” [VC-9].

The CPCC-volunteer counsellors spoke about how close the CPCC is to two tertiary institutions, as well as a few other colleges and schools; they referred to the centre being on a bus route in a quiet suburb, which facilitates relatively easy access. The building, a house which has been renovated and converted into offices, is nondescript with no huge notice boards advertising that services related to crisis pregnancies and TOPs are being rendered there. Appointments for counselling and support are made personally or telephonically (24-hour telephone assistance is available) and even “walk-ins” (where clients present without a formal appointment) are accommodated as far as possible.

- d) Category 4.1.4: Having the option to refer students and having resources to refer to as a resource for service delivery

A detailed discussion of the participating SPs’ utilisation of several referral options/systems in their service delivery to TSs with UPs and/or TOPs (namely their liaison with other welfare and/or community resources, tertiary institutions, and related departments within the tertiary institutions, as well as fellow colleagues) was presented earlier in this chapter (see Section 5.3.3.1).

In this category a summary of the participants’ responses, confirming their perception of the resource value of these referral options and systems, is presented:

“It really helps a lot that there are organisations out there [referring to community organisations] that we can use if a pregnant student considers options like adoption or foster care...” [VC-1].

“The support is available on campus... it is so nice to just send the student to the campus clinic for a pregnancy test... or the [campus clinic] nurse will send the student to us... with a note that the student is pregnant and that she needs counselling and support regarding the options...” [SW-1].

“And the support that we get for the student when we liaise with her residence manager, or her lecturer, the academic department... I have had positive experiences in this regard...” [Ed-Psych-1].

“We also get a lot of help and support from campus security, the police, the community clinics, and the provincial hospitals... I saw this student who was raped, and she fell pregnant... I don’t know what I would have done without their help...” [HCP-2].

Aside from highlighting certain elements in their service delivery to TSs with UPs and/or TOPs that they perceive to be resources, the participating SPs also shared information about the obstacles encountered by them in this regard. The next sub-theme consists of a presentation of these hindrances.

5.3.4.2 Sub-theme 4.2: Obstacles encountered by SPs in their service delivery to TSs presenting with UPs and/or TOPs

The obstacles spoken about by the SP-participants are presented under six categories. Of interest in this regard was that aspects some of the participants labelled as an obstacle were experienced by another participant as a resource. Where necessary and appropriate, these differences are noted and contextualised.

a) Category 4.2.1: Lack of finances as an obstacle to service delivery

The obstacle relating to lack of finances was specifically mentioned by the volunteer counsellors from the participating CPCC. The latter is a registered a NGO, relying on donations and financial support from, amongst others, churches, private companies, and individuals to offer their services.

Over the past few years, the role of NGOs in South Africa has received much attention. Their value is recognised, as the NGOs more often than not are the organisations that fill the social welfare service “delivery gap” in our society, meeting the basic social support needs of many. However, the financial and human resource capacity challenges that they face, as with many NGOs worldwide (Hume & Leonard, 2014:295), unfortunately have resulted in many of them having to close down or scale back their activities.

The volunteer counsellors spoke about the lack of finances as obstacle to their service delivery along the following lines:

“Financial resources...that we don’t have enough... we need a lot more of that...”
[VC-3].

“...the economy... the financial side is unfortunately something that we, as an NGO, face on a daily basis. It would’ve been wonderful if we could have enough finances to market... to take the services out there... but due to [a lack of] finance we can’t ...” [VC-9].

“...on the [utilisation of] information technology and... I’ve been to England last year and they have the whole online counselling programme there where girls can go online... I think that would be my biggest strength... dream to utilise IT for bettering... and expanding our service here... but for that we need money...” [VC-1].

- b) Category 4.2.2: Staff-shortages and language and cultural barriers as obstacles to service delivery

In substantiating this category, the following storylines are provided:

“...to get more volunteers... I think the restrictions of not having enough people also – it’s a big thing, we would be able to do so much more with more involvement [by volunteers]” [VC-6].

“I think definitely not enough staff – that is a huge problem... it really interferes with the services that we offer, we just do not have enough people” [VC-7].

“...lack of resources... at the moment... I mean... we are short of a doctor” [HCP-1].

“...however, we still lack human capacity... we have to have some targets in terms of our health promotion, but it’s not possible for us to always reach our targets because of a lack of human resources. We have one health promoter, we have one HIV-coordinator, and we have two nurses. So the nurses are always in the clinics and the... the health promoter and HIV-coordinator always are the ones who have to do the campaigns, and they don’t cope...” [HCP-1].

The assertion that lack of manpower restricts the quality of service delivery, as mentioned by the participants quoted above, resonates with and is confirmed by several scholars (Levi et al., 2009:311; Oliphant, 2009:12; Rosenberg, 2008:27, 238), who state that this could result in students not receiving the quality attention, care, and support they require. The lack of manpower, especially within the context of student sexual health and education, may jeopardise the window of opportunity that arises when a TS approaches a healthcare practitioner for a pregnancy test or a counsellor for advice and guidance related to UP-options. If such opportunities are exploited by the SP to the full extent, it could lead to the effective management of the UP-crisis. The lack and unavailability of resources/support for TSs presenting with UPs and/or TOPs may result in impulsive decision making, which is often regretted at a later stage (Miller, 2011:71; Levi et al., 2009:311; Rosenberg, 2008:238).

The experience of language and cultural barriers as a hindrance in service delivery was mentioned by one of the volunteer counsellors who stated: *“I really think language is also a problem – we’ve only got two Black... African counsellors at this stage and, and they only come in when we ask them, so when a girl sits here and she’s really struggling to express herself... that is a restriction as well...” [VC-4].*

HCP-2 also made reference to language as a barrier to service delivery when saying: “...sometimes the White, Afrikaans-speaking students ask to rather see ‘Sister B’” [Pseudonym for her colleague, who is White and Afrikaans-speaking].

The diversity of the South African population challenges SPs to increase the availability of their services in racially and ethnically diverse localities (Van Breda, 2011:24). An increasing demand for the provision of culturally appropriate assessment, intervention, and prevention seems to be appropriate and the development of an awareness of cultural values, such as reliance on family support systems, collective decision making, spirituality, and respect for peers, is seen as paramount in service delivery to diverse populations with the ability to understand and respect a prospective client's belief system being described as crucial (Lee, Blando, Mizelle & Orozco, 2010:51).

SPs offering support services to TSs with UPs and/or TOPs are providing care, education, and case management to a diverse client population that is challenged with a triad of cultural, linguistic, and health literacy barriers. For these clients, culture and language set the context for the acquisition and application of health literacy, as well as psychosocial skills. The importance of integrating cultural and linguistic considerations into helping efforts is emphasised by several authors (Miller, 2011:71; Levi et al., 2009:309; Singleton & Krause, 2009) and SPs are encouraged to be aware of the following in this regard:

- Some prospective clients may prefer practitioners of the same gender.
- Be mindful of topics that may elicit highly sensitive reactions, for example the history of an individual's sexual activity.
- Ensure that the office environment, including artwork and the arrangement of furniture, is respectful of cultural beliefs and values.
- Students' lack of knowledge and/or misperception about available services, which could aggravate the already wide disparity between the need for support services and the availability of these services.

Lee et al. (2010:217) reiterate that while some clients might want support from a SP that they can culturally or linguistically identify with, others do not. The importance of focusing on how to embark on offering support to the mentioned

client system in a way that best integrates cultural differences between client and SP is thus emphasised. SPs are encouraged to integrate cultural and linguistic considerations into daily efforts to effectively communicate with culturally diverse students. Mentioned authors reiterate that, over the coming years, effective service delivery to TSs presenting with UPs and/or TOPs will not be the mere inclusion of health and psycho-education alongside cultural and linguistic competence. It will require and rather be an “expanded paradigm that involves the substantive integration of all three (mentioned aspects) in ways that are practical for SPs to implement and that make a difference in the client experience of support” (Lee et al. 2010:51).

- c) Category 4.2.3: The location and distance between student service departments at the tertiary institutions as an obstacle for service delivery

A statement made by HCP-1, which gave rise to this category, illuminates the aspect of location as an obstacle: *“The counsellors [referring to the student counselling unit of the tertiary institution] are on [referring to one of their campuses] ...campus and we [referring to the campus clinic] are on the [referring to another campus] ...campus... Yes, they think... you know when you say – ‘Go to [student counselling], you’re just dumping them’. And it... would be better if maybe there was [a social worker] here, you know, based here in the clinic... and not on our other campus.”*

During my fieldwork, I observed that at most of the participating tertiary institutions the student service departments (campus clinics and the student counselling units) were not housed under one roof, as mentioned by HPC-1 above. Whilst the SPs made reference to the referral of students between service departments on campus/campuses, which was indicated as a resource favouring comprehensive service delivery to the student population, the lack of a one-stop location housing all student service departments appears to be an obstacle to effective service delivery. This state of affairs once again underscores the claim made by several scholars, namely that on-campus support services need be improved and more readily available/accessible as a buffer for the non-utilisation of such services (Baird & Porter, 2011:156; Bafana, 2010:11; Patel & Kooverjee, 2009:552).

- d) Category 4.2.4: Facilitation of the termination of an UP with relative ease by the Choice on Termination of Pregnancy Act 92 of 1996 (South Africa 1996) as an obstacle to service delivery

For many a TS in the quagmire of an UP, a TOP is viewed as an easy way to deal with the problem (Pickles, 2012; Panday et al., 2009:25) as it is regarded as a secret, quick, and affordable solution to the predicament they find themselves in (Kjelsvik & Gjengedal, 2011:172; Rosen, 2010:23).

In addition to the mentioned Act legalising or normalising the TOP, it has, in the context of tertiary education, been found to provide students presenting with an UP with an opportunity to protect and pursue their educational goals (Van Breda, 2011:24; Rosen, 2010:23; Panday et al., 2009:25). Several scholars (Miller, 2011:69; Patel & Kooverjee, 2009:553; Palanivelu & Oswal, 2007:832) state in this regard that, although emphasis is placed on the fact that a TOP should not be regarded as a form of contraception or population control, it is treated as such amongst the TS population and within the South African context. Where an UP often results in a crisis where a student has to drop out of university, a TOP is increasingly being seen as an alternative or a form of emergency contraception when required. This state of affairs corrodes the sense of responsibility for one's own sexual health and wellbeing (Baird & Porter, 2011:155; Sekgobela, 2008:25). This trend, according to Thomas (2012:3), causes South Africa's current TOP-legislation to be regarded as permissive, as it allows for the termination of first and second trimester pregnancies on demand. (Pickles, 2012; Thomas, 2012:3; Miller, 2011:2; Yunos, 2010:4).

The SPs' accounts (below) resonate with the views from the authors referred to above, namely that the Choice on Termination of Pregnancy Act 92 of 1996 (South Africa 1996) facilitates the termination of an UP with relative ease.

“And the law... because the law says abortion is absolutely fine... and... and that is a great restriction in our work... The fact is, the law gives permission, but the law doesn't give responsibility” [VC-5].

“I feel that the TOP Act just makes it so easy for the student to go for an abortion... I know of a student who had two TOPs last year” (HCP-1).

- e) Category 4.2.5: TSs’ non-utilisation of available resources as an obstacle to service delivery

The non-utilisation of available resources, often resulting from a lack of awareness, fear of stigmatisation or judgement, or financial and/or time constraints, was another hindrance experienced and expressed by the SP-participants, as the following utterances attest:

“You know, we do a lot to inform the students of our services... but still we find that many of them are not aware of the support offered by the counsellors on campus or even the campus clinic” [Ed-Psych-4].

“They don’t know that they can get counselling and medical support free of charge on campus” [HCP-2].

“We find that those students who actually do know about the support services available on campus are afraid to make use of it. They seem to be afraid of being judged, or stigmatised... some of them just don’t want to be seen at the offices of Student Counselling... it really limits us” [C-Psych-4].

“I have referred students to the provincial hospital and even to some community clinics but then... they have to sit and wait for hours before they see a doctor or specialist... they miss class or a test and many of them told me that it is not possible for them to lose a whole day just to go to hospital... so they just don’t go” [VC-2].

“...and, financial constraints as well... many students don’t have the transport money to go to a community clinic, or the hospital... they can’t walk there, they have to take a bus or a taxi and they don’t have money... it makes it very difficult for us... referring them, but they can’t go...” [HCP-2].

The reasons for the non-utilisation of available resources were elaborated upon earlier in this research report and also substantiated from the literature consulted (see Sections 1.1.1.2, 4.3.3, and 5.3.1.3). The SPs testimonies indicate that students' non-utilisation of the support services available to them increases their psychosocial vulnerability, which ultimately could impact negatively on their academic attainment (Van Breda, 2011:24; Rosen, 2010:18).

- f) Category 4.2.6: Tertiary institutions' residential policies with regard to student pregnancy as an obstacle to service delivery

The TS-participants referred to the tertiary institutions' residential policies concerning student pregnancy in that they suggested the amendment of rules/policies regarding accommodation in order to provide pregnant students with safe and secure accommodation until childbirth (see Section 4.3.4 – Category 4.1.3).

The SPs regarded these policies as a hindrance to service delivery as deduced from their accounts below:

“Another problem is... that the residences have got... a policy that they [referring to pregnant students] cannot stay in the residence for longer than six months. Thirty-four weeks, and then they must look for another place to stay and usually that is a big problem” [VC-6].

“Our Residence rules prescribe that a pregnant student is not allowed to reside in the residence after her fifth or sixth month of pregnancy. That causes severe stress for the students and we struggle to assist them to find suitable, safe accommodation” [SW-1].

This stress referred to by SW-1 above is also alluded to by several other SP-participants who, with regard to their perceptions of the support needs of TSs with UPs and/or TOPs (discussed in Section 5.3.2), note that in addition to the fear experienced by TSs that do not have a place to stay as a result of their UPs, it also has a direct bearing on the decision-making process regarding the UP (Van Breda,

2011:5; Martin & Oswin, 2010:57; Wilks & Spivey, 2010:286; Arhin & Cormier, 2008:215).

The presentation of the sub-theme on the obstacles encountered by the participating SPs in their service delivery to said client system group is herewith concluded.

I will now proceed with a presentation of the next theme that emerged from the processes of data collection, data analysis, and the consensus discussion, namely: the SP-participants' suggestions for informing practice guidelines for psychosocial support to TSs presenting with an UP and/or TOP.

5.3.5 Theme Five: SPs suggestions for informing practice guidelines for psychosocial support to TSs presenting with an UP and/or TOP

The responses of the SPs which lead to this theme (unfolding in two sub-themes) was prompted by the last question that was directed at them during the data collection process: *“Based on your experiences as SPs rendering support services to TSs presenting with UPs and/or TOPs, what suggestion(s) do you have on how these students can be supported by SPs in practice?”*

This theme relates to the aspect of *“Strategies”* in Schlossberg's (Schlossberg, 2011:161; Workman, 2015:5) Transition Process Model in that it highlights how psychosocial support should be provided to TSs presenting with an UP and/or a TOP to enhance their abilities and strategies to cope with the transitions and to make informed decisions that will change or reframe the situation in order to reduce stress and put their lives back on course.

The verbal accounts of the participants indicated that they had specific suggestions regarding the format and content (in other words, the core elements) of the proposed practice guidelines, as well as recommendations regarding the prerequisites related to the implementation thereof. The first sub-theme, consisting of their suggestions regarding the core elements, is consequently presented.

5.3.5.1 *Sub-theme 5.1: SPs' suggestions on the format and content of psychosocial support to TSs presenting with an UP and/or TOP*

The following accounts of the SP-participants showcased their suggestions with regard to psychosocial support being offered through individual counselling, group work and community outreaches, as well as the aspects to be covered by these methods.

"...and personal counselling ... [It's] very important to deal with related issues like self-esteem and why did they [the students] get pregnant in the first place... these issues should be addressed in individual counselling..." [C-Psych-4].

"...the emotional counselling, after the crisis counselling... one-on-one counselling to help the student deal with the trauma" [VC-5].

"Counselling services for those have intent to go for abortion. Those that have had abortions – so it will be about all the counselling support services..." [Ed-Psych-1].

"...an online counselling service... where the student can go online and get advice and support and counselling... without having to go to an office, make an appointment with a counsellor... just go online" [VC-6].

With reference to suggesting the provision of psychosocial support in a group work format and the topics to be covered in such groups, the following storylines are provided:

"...also support groups... life skills... information groups... small groups... a continuous programme that runs and then anyone can join at any point and just join in with what's happening" [VC-2].

"... [groups on] parenting... relationships... sexual matters... a support group in the residences..." [SW-1].

“...I think in a support programme. It would probably be nice to have a support group where pregnant women, girls, students, could actually meet each other and... unburden themselves and... talk... and get ideas from each other on how to manage and cope and a... support group for student moms whose kids are not here” [C-Psych-4].

Outreaches to the student community and further afield in the form of workshops, exhibitions, and awareness campaigns, as well as topical suggestions, were made as deduced from the storylines below:

“Workshops and outreaches in residences... I think it’s so important just to go also in the residence and maybe have a workshop on... sexuality, and all those reproductive health issues – knowledge and information about that” [SW-1]

“...but for the prevention part it’s outreaches to give information, health talks, radio talks, promotional materials, and all those things” [HCP-1].

“I think that more time must be spent in preventative programmes with the students where the reality is spoken to and not in a preaching way. I think exhibitions are very effective... community work on micro level... workshops, campaigns” [VC-1].

The SP-participants furthermore reiterated that the above-mentioned support should be offered to all students and should not only be aimed at female students, as the following utterances illustrate:

“I think it’s so important that the boys are involved too... we should include them... in all our attempts... it [referring to the above-mentioned suggestions for support] shouldn’t just [be] an all-girls thing” [VC-10].

“And we should involve and include all our students, from first year to final year, male and female” [C-Psych-3].

The participants' topical suggestions interspersed between the aforementioned quotations have a strong psycho-educational focus, which was also noted in the following suggestions forwarded by them in terms of providing psychosocial support in view of the practice guidelines recommended for this purpose:

"The students should have a life skills course... to create an understanding of sexuality... one's body... healthy sexuality... it should be presented to all the students" [VC-7]

"...information about safe sex... STDs" [C-Psych-2]

"Okay, from a health and wellness perspective it could be like maybe we should have a... some ante-natal classes whereby we give them information related to their pregnancy" [HCP-1].

"...sexual education. Reproductive health education – and biology of how their body functions. The use of condoms, the use of contraceptives" [Ed-Psych-4].

"...the options... parenting, or TOP... what to do when you are pregnant, how to prevent further pregnancies" [VC-6].

"...dealing with a relationship should be part of the life skills... how to deal with relationships, how to have healthy relationships, relationships with yourself, with the people around you" [SW-2].

"...by teaching them how to budget, how to manage their money, by teaching them what's important and what isn't important" [C-Psych-3].

The SPs also recommended marketing the psychosocial support to the student population. The following utterances make reference to this:

"More awareness of services and resources so yes, more effective marketing... guidelines... all students need to be informed about it" [SW-1].

"...so promotion of services, I think, is crucial" [HCP-1].

“Design a pamphlet... the information needs to be on a pamphlet... maybe telling students about what to do when they find themselves in that situation, mmm... where to go, and... where to find help...” [C-Psych-4].

“[Advertise the services] ...on notice boards... in the residences... the places where they walk past every single day... the library, dining room... universities’ radio stations...” [VC-4].

Before turning to the literature to find support for these suggestions forwarded by the SP-participants, I have to note that some of the topical suggestions are not only directed at students with an UP and/or TOP, but to the student population in general. These suggestions carry a strong preventative, life skill and life orientation focus.

The literature consulted highlights individual/face-to-face, online, and telephone counselling as measure to provide psychosocial support with the focus of these counselling efforts being on crisis pregnancy counselling; pre and post-abortion counselling; and relationship counselling with the purpose of increasing the psychosocial coping mechanisms of the TS presenting with an UP and/or TOP, as well as reducing the many stresses experienced (Kjelsvik & Gjengedal, 2011:172; Van Breda, 2011:6, 20; Burgen, 2010:28, 32; Levi et al., 2009:308; Burgen, 2010:28; Martin & Oswin, 2010:60; Wilks & Spivey, 2010:282; Brosh et al., 2009:3).

Several scholars, with regard to the SPs’ recommendations for support groups, underscore the value of such groups for young unmarried women when dealing with a life challenge such as an UP or a TOP, irrespective of these support group sessions being facilitated by a trained and qualified professional or being informally and spontaneously conducted (Baird & Porter, 2011:153; Corkin, 2011:4; Aujoulat et al., 2010:452; Rosen, 2010:16; Sekgobela, 2008:110; Brosh et al., 2007:4; Naidoo & Kasiram, 2006:350).

In latching on to the SPs’ recommendations pertaining to community awareness through workshops, outreaches, and information campaigns, various scholars

(Miller, 2011:69; 72; Adams & Williams, 2011:1883; Rosen, 2010:16) advocate for a strong preventative focus in these, as well as for the provision of correct information, in a sensitive and user-friendly fashion, on topics such as safe-sex practices, contraception, the available UP-options, and the resources available for support in this regard.

Levi et al. (2009:305) purport the destigmatisation and normalisation of contraceptive, UP, and TOP-services by including it as “an integral part of effective service delivery with regard to awareness and information campaigns” within a preventative framework (Levi et al., 2009:305). Including these topics into the broader spectrum of the sexual health discourse through various educational and counselling avenues should result in increased utilisation of appropriate support services and ultimately the educational attainment of many students dealing with UPs and/or TOPs (Van Breda, 2011:26; Steck, 2011:44; Brosh et al., 2007:575; Ratlabala et al., 2007:30).

The SPs’ recommendations that psychosocial support, irrespective of the focus, should target all students find support in the work of Kjelsvik and Gjengedal (2011:172), Van Breda (2011:20) and Burgen (2010:31). These scholars aver that sexual health-related challenges cut across all races, classes, and genders.

5.3.5.2 Sub-theme 5.2: SPs’ additional suggestions for the offering of psychosocial support to TSs presenting with an UP and/or TOP

The suggestions of the SPs led to this sub-theme, which branched out into several categories.

- a) Category 5.2.1: Psychosocial support to TSs should be enhanced through better networking, cooperation, and referrals between tertiary institutions, significant others, and community resources

In support of this suggestion, the following participant accounts are provided:

“We should take hands with other organisations, academics or other people, counsellors, clinics...” [Ed-Psych-3].

“Networking and working together with others in the field... as well as with the parents or the family... it is so important...” [VC-5].

“Referrals and liaison with others, it should be... smoother... there are people out there that we can work with, but sometimes we struggle to find assistance” [HCP-2].

“...Involve the boyfriend, the partner... better cooperation with him... you know, regarding the decision-making process... also with the parents, or the family of the student. And establish relationship with community resources...” [SW-1].

Strengthening the SPs in better networking and collaboration, and establishing and maintaining a well-organised and comprehensive contact/resource list for the purpose of holistically and comprehensively assisting TSs presenting with UPs and/or TOPs is advocated (Kjelsvik & Gjengedal, 2011:174; Van Breda, 2011:21; Wilks & Spivey, 2010:281; Ekstrand et al., 2009:178).

Furthermore, the on-going networking with other SPs, internally and externally, the establishment and maintenance of good relationships with fellow professionals and organisations, as well as liaison/cooperative agreements with lecturing/academic staff and other tertiary institutions is accentuated by several authors who describe this prerequisite suggested by the participants as imperative when assisting with the personal, social, and academic challenges associated with an unintended pregnancy or TOP (Van Breda, 2011:8; Martin & Oswin, 2010:59; Arhin & Cormier, 2008:215).

- b) Category 5.2.2: The practice guidelines for psychosocial support to TSs presenting with an UP and/or TOP should be user-friendly, holistic, flexible, and disseminated to all relevant role players

The following utterances illuminate the suggestions of the participants in terms of this prerequisite:

“All of us [referring to all SPs rendering support services to TSs with UPs and/or TOPs] should have access to the practice guidelines and it should be easy to apply and to use” [C-Psych-1].

“...it needs to be holistic so you’re looking at all different aspects – you’re looking at issues of gender, issues of identity, values, religion, culture... family, support, academics” [C-Psych-2].

“...this [referring to the proposed practice guidelines] should not be just... you know, just a once-off thing – it must be an on-going thing” [HCP-2].

“... [referring to the purpose of the practice guidelines] to guide... to assist with providing a holistic service [therefore] covering everything... medical... and counselling, guidance” [VC-6].

“I think then it would mean disseminating the information – it’s a dissemination of the practical guidelines, possibly policies that emanate from that... that would be important as to... disseminate it to all the different role players, internally and also externally. And then maybe putting in place specific structures after that. Because now you’ve got the guidelines, you’ve got policies – you have to share it with all the relevant role players” [SW-1].

In the context of this study, the concept practice guidelines (also clarified and elaborated upon in Section 1.5.2) refers to the provision of a strategy for SPs in order address a specific social problem; in other words, what to do when addressing a specific social problem as well as how to do it (Hepworth et al., 2013:435). I adopted the definition of Proctor and Rosen (2003:109) who define

practice guidelines as “a set of systematically compiled and organised statements designed to enable practitioners to find, select and use appropriately the interventions that are most effective for a given task” for this research endeavour and I wish to, in this regard, concur with the views of several scholars who accentuate the importance of the mentioned strategies meeting the following requirements:

- They should be presented/written in an uncomplicated manner (in easy, understandable language) (Van der Westhuizen, 2010:209).
- They should include all aspects deemed relevant and related to service delivery to TSs with UPs and/or TOPs (for example, contraception, crisis pregnancy support, UP-options, TOP-counselling and support, etc.) (Adams & Williams, 2011:1877; Baird & Porter, 2011:155; Levi et al., 2009:309).
- They should enable SPs to measure their input (Van der Westhuizen, 2010:209).
- They should allow the impact of the measures and interventions to be evaluated and adjusted, if necessary (Van Breda, 2011:26).
- They should address the need expressed by SPs for comprehensive support guidelines (the rationale for this study was, amongst others, based on this need, expressed and elaborated upon in Section 1.3) and it should be disseminated to all relevant stakeholders (Van der Westhuizen, 2010:210).

- c) Category 5.2.3: The practice guidelines should inform tertiary institutions' policies related to student pregnancy

The findings of this study confirmed that the majority of higher education institutes do not have specific policies in place for supporting students with UPs and/or TOPs and that the rules and regulations, of which some examples were elaborated upon earlier in this research report, are perceived by both participant groups as restrictive to service delivery⁴⁶ and a limitation in terms of the educational attainment of TSs dealing with these life challenges.

The following storylines attest to this category:

"It would be nice if there could be one standard policy... maybe even a national policy that applies to all students" [Clin-Psych].

"...and perhaps the findings of this research can be used to inform a policy for student pregnancies that can be implemented at tertiary level" [Ed-Psych-2].

"...Another thing... when you implement the guidelines you need to do some research as well to linking... comparing to what others in similar sittings are doing – like other institutions, with the aim of [benchmarking] as well. If there are institutions that have implemented these guidelines, what is the impact" [C-Psych-3].

"...So all policies that relate to student pregnancy should be aligned with the practice guidelines... then we take it to top management, it is approved, and it's going to the Senate, and it's approved, and it must be accepted as a university policy" [SW-1].

⁴⁶ The perceived restrictive nature of the rules and regulations with regard to residence accommodation, namely: that pregnant students are generally only allowed to reside in university accommodation until the fifth or six month of pregnancy were elaborated upon by both participant groups. The SP participants expressed that they perceived this to be an obstacle to their service delivery (see Section 5.3.4.2) and both participant groups, in offering suggestions for support to TS presenting with UPs and TOPs, recommended that these rules and regulations be reviewed (also see Section 4.3.4).

“And I think perhaps the findings from your research [referring to this research endeavour] may be very important in revising current rules... or policies – the current policy, because... I’m not too clear on exactly what’s in the current policy, but I don’t know how much there is there that actually can assist the students” [HCP-2].

Aside from the five main themes presented above, a unique theme resulted from the data analysis process and the consequent consensus discussion. This theme relates to the participating volunteer counsellors’ expression of the positive experience of the specialised training that they receive (see Section 5.3.4.1) with regard to their service delivery to women presenting with UPs and/or TOPs. The suggestions made by the SPs from the participating tertiary institutions, namely that SPs rendering support services to TSs with UPs and/or TOPs should receive specialised and on-going training to assist them in their service delivery, consequently gave rise to this theme, which will be presented next.

5.3.6 Unique Theme: SPs rendering support services to TSs presenting with UPs and/or TOPs should receive specialised and on-going training (specifically related to the phenomenon)

The following accounts of the SPs from the participating tertiary institutions attest to their acknowledgement that crisis pregnancy and TOP-counselling and support is a specialised field of service delivery.

“This [referring to the phenomenon of UPs and TOPs] is a specialised field, so we need... to be educated, like a training workshop or programme addressing the unique aspects related to unplanned pregnancy, abortion and... specialised training... we need to have places that we can refer to, with confidence, and we need to be informed regularly of new developments in the field in terms of medical aspects or even counselling approaches...” [SW-1].

“We should also be... you know... [be] trained... in counselling students with these issues [referring to students presenting with UPs and/or TOPs] ...and the training should be specific and specialised...” [Ed-Psych-4].

“...the medical training... A specialised programme to address the medical aspects related to pregnancy and TOPs... practitioners working in this field, and not only the nurses, need to be informed about the medical aspects...” [HCP-2].

“And experts must train us... even if you are a psychologist or social worker or nurse... we need specific information and training, offered by specialists in the field. And the training must be on-going” [C-Psych-2].

The above-mentioned acknowledgements are underscored by several authors (Baird & Porter, 2011:156; Burgen, 2010:23; Levi et al., 2009:312) who also emphasise the importance of ensuring that the format and content of the mentioned specialised and on-going training are characterised by adequate, appropriate, tailor-made elements (Baird & Porter, 2011:156; Burgen, 2010:23). Empowering SPs with specialist knowledge, information, and training in this regard and encouraging continued professional development is strongly suggested by the mentioned authors, as these factors have been found to have the potential to improve the efficacy of service delivery to those rendered vulnerable as a result of experiencing a life challenge such as an UP or TOP (Van Breda, 2011:26).

The description of the research findings relating to the perceptions of the SP-participants regarding the experiences and support needs of TSs with UPs and/or TOPs, the scopes of the support services offered by them, as well as their suggestions for informing practice guidelines for psychosocial support to TSs presenting with an UP and/or TOP is herewith concluded.

5.4 CHAPTER SUMMARY

The research findings presented in this chapter were based on the data obtained from 23 participating SPs. The process of data analysis resulted in the emergence of five main themes and one unique theme, with the main themes being divided into sub-themes and categories, which in turn were underscored by complementing storylines from the participants and verified with relevant literature and previous research findings.

The presentation of the research findings was preceded by a discussion of the demographic details of the participants. This presentation revealed that the majority of the participants fell in the age group 30-49 years and that all of them were female, with the exception of one participant who was a counselling psychologist from one of the participating tertiary institutions. It was furthermore found that, with the exception of two participants (two volunteer counsellors from the participating CPCC), all of the participants were in possession of a tertiary qualification. Of the 13 participants from the tertiary institutions, 12 indicated that they obtained post-graduate qualifications. The majority of the participants furthermore indicated that they had a minimum of six years' experience in providing services to TSs with UPs and/or TOPs.

The discussion of the findings relating to the demographic details of the participants was followed by a tabulated overview (see Table 5.3) of all the themes, sub-themes, and categories that emerged from the data analysis process.

Theme One, which unfolded in three sub-themes and two categories, focussed on the SPs' perceptions about the prevalence, impact, and reasons for the occurrence of UPs and TOPs amongst TSs.

The SP-participants' perceptions of the experiences and support needs of TSs with UPs and/or TOPs were presented in Theme Two. This theme was divided into two sub-themes and 10 categories, which illuminated their perceptions of the feelings and emotional reactions experienced by TSs presenting with UPs and/or TOPs, as well as their perceptions that this client system group needs counselling, and on-campus medical and academic support.

An elaboration of the scopes of support services offered by SPs to TSs presenting with UPs and/or TOPs was presented in as Theme Three. This theme unfolded in two sub-themes and three categories, which focussed on the scopes of the counselling and medical support services offered by the participants.

Theme Four, which unfolded in two sub-themes and 10 categories, consisted of a presentation of the SPs' accounts of the resources available and obstacles encountered in their service delivery to TSs with UPs and/or TOPs.

The last main theme, Theme Five, comprised the SPs' suggestions for informing practice guidelines for psychosocial support to TSs presenting with an UP and/or TOP. This theme unfolded into two sub-themes and three categories, which illuminated their suggestions regarding the core elements (the format and content) of the proposed practice guidelines, as well as several additional suggestions for the offering of psychosocial support to said client system group.

The unique theme that emerged as a result of the data analysis process comprised the participants' suggestion that SPs rendering support services to TSs with UPs and/or TOPs should receive specialised and on-going training.

The next chapter of this research report consists of the practice guidelines for psychosocial support to TSs presenting with UPs and/or TOPs. These guidelines are based on and informed by the research findings of this study, the theoretical framework that was adopted for this study, namely Schlossberg's Transition Process Model (Schlossberg, 1981), as well as the legislative and policy frameworks available to guide the provision of psychosocial support to women presenting with UPs and/or TOPs, with the latter forming the foundation for the practice guidelines and providing the prerequisite knowledge required for service delivery to TSs presenting with UPs and/or TOPs.

CHAPTER SIX:

PRACTICE GUIDELINES FOR PSYCHOSOCIAL SUPPORT TO TSs PRESENTING WITH AN UP AND/OR TOP

6.1 INTRODUCTION

This chapter, proposing the practice guidelines for psychosocial support to TSs presenting with an UP and/or a TOP, ties in with the last of the research goals formulated in respect of the TS and SP-participants respectively (see Section 2.3). The practice guidelines as such are based on the experiences and needs of the students who were confronted with an UP and/or a TOP (reported in Chapter Four of this thesis) and their suggestions for psychosocial support, as well as the accounts of SPs who shared their perceptions about the experiences and needs of these students; the scopes of the services they offered to these students; and the suggestions they forwarded for providing psychosocial support to such students as presented in the previous chapter of this report.

The concept “practice guidelines” as conceptualised and contextualised for the purpose of this study (see Section 1.5.2) refers to “systematically developed statements to assist practitioners” (Cohen, Gerding, Johnson, Kelly, Loo, MacDonald, Pepin & Wilcox, 2010:434) in terms of “what to do” and “how to do it” (Hepworth et al., 2013:435; Proctor & Rosen, 2003:109), with reference to psychosocial service delivery to TSs presenting with an UP and/or a TOP. As such the psychosocial support includes, but is not limited to, assisting with the assessment of the presenting problem in terms of the UP and/or TOP and its aftermath, and selecting and implementing a plan of action or intervention to assist the TS presenting with the UP and/or TOP.

These practice guidelines, founded on the literature and empirical research conducted for this study and presented in this chapter, aim to provide directives and pointers to SP on how to -

- establish a helping relationship with a TS presenting with the concern of an UP and/or a TOP; and

- assess and intervene in the **situation**, the **self**, the **support**, and the (coping) **strategies** surrounding the TS's UP and/or TOP. These mentioned facets of the situation, self, support, and strategies are known as the 4S-system in Schlossberg's Transition Process Model (Anderson et al., 2012; Schlossberg, 2011; Schlossberg, 1981) (see Section 1.4) adopted as theoretical framework for this study. As explained by Schlossberg (1981:6), an event (such as an UP and/or a TOP for a TS) puts in motion a transition phase marked by changes in relationships, routines, assumptions, and roles. During this transition, a roller coaster of feelings and emotional reactions are experienced (cf. Mnyango, 2015:17; Schlossberg, 2011:159; Evans et al., 1998:111-112). How individuals adapt to transitions by moving from being totally preoccupied with the transition to integrating it into their life (Schlossberg, 1981:7) will be dependent on the assets or deficits present in the situation and the self, as well as the convoy of support and coping strategies they have available, which in sum will either help or hinder the adaptation to transition.

Note: The practice guidelines on how to assess and intervene during the provision of psychosocial support to TSs presenting with an UP and/or a TOP will be organised according to Schlossberg's 4S-system mentioned above.

The practice guidelines are also geared for providing psychosocial support in a one-on-one counselling situation.

Before presenting the practice guidelines, I deemed it necessary to provide an overview of the policy frameworks and legislation underpinning the proposed practice guidelines.

6.2 POLICY FRAMEWORKS AND LEGISLATION UNDERPINNING THE PRACTICE GUIDELINES FOR PSYCHOSOCIAL SUPPORT TO TSs PRESENTING WITH AN UP AND/OR A TOP

The presented guidelines for providing psychosocial support to TSs presenting with an UP and/or TOP were developed from a social work perspective with the

reason being that, apart from the fact that I was engaged in this project as the researcher, I am also a practicing social worker.

Against this background, the practice guidelines proposed are imbedded in the following policy frameworks:

- the White Paper for Social Welfare (1997);
- the Integrated Service Delivery Model (ISDM) for Developmental Social Services (DSD, 2005); and,
- the Framework for Social Welfare Services (DSD, 2013).

The White Paper for Social Welfare (1997) (hereafter indicated as the White Paper) is premised on a *developmental approach*, taking into account the strengths of the individual, group and community, as well as the promotion of their capacity for growth and development. According to the White Paper (1997), developmental social welfare policies and programmes should be based on the following guiding principles: securing basic welfare rights, equity, non-discrimination, democracy, improved quality of life, human rights, people-centred policies, investment in human capital, sustainability, partnerships, intersectoral collaboration, decentralisation of service delivery, quality of service delivery, transparency and accountability, accessibility, appropriateness, and uBuntu⁴⁷ (DSD, 2013:5, 13; DSD, 2005:17, 20). This developmental approach to social welfare as espoused in the White Paper (1997) and adopted by the DSD as an approach to social welfare service delivery was translated into **the ISDM**, developed by the DSD in 2005 (DSD, 2005) “to give effect to the developmental approach” (DSD, 2013:5). Its primary objective is to provide a comprehensive national framework that clearly sets out the nature, scope, extent, and level of social services. The DSD (2005:14) describes the desired outcome of the ISDM as “the implementation of a comprehensive, efficient, effective, quality service delivery system that contributes to a self-reliant society”. The White Paper (1997)

⁴⁷ South Africa, as a multi-cultural, multi-racial, and multifaceted country, embraces the concept of uBuntu as a way of defining who we are and how we relate to others. The concept is founded on the principles of “do as you would be done by” and “I am because we are”. Aside from uBuntu referring to the way individuals treat each other, with the emphasis being on humanity, caring and sharing, it denotes a state of being and one of becoming; a process of self-realisation through others as well as the enhancement of the self-realisation of others (Humanity’s Team South Africa, n.d.).

and the ISDM for Developmental Social Services, after a recent intense review and stakeholder scrutiny (in 2013), were enunciated in **the Framework for Social Welfare Services** (DSD, 2013). The aim of this policy framework reads as follows: “The Framework seeks to facilitate/guide the implementation of a comprehensive, integrated, rights-based, well-resourced and quality developmental social welfare service” (DSD, 2013:9).

In both the ISDM for Developmental Social Services (DSD, 2005) and the Framework for Social Services (DSD, 2013:27-35) the collective responsibility of several role players, inclusive of government departments and non-governmental, community-based, and faith-based organisations, as well as practitioners from the private sector (DSD, 2013:15; DSD, 2005:48), is mentioned in terms of social welfare service delivery. In addition, the roles and responsibilities of SPs in the different mentioned spheres are outlined in order to ensure role clarification; to prevent the duplication and fragmentation of services; and to ensure that the services being offered are integrated, coordinated, and managed to maximise their benefits to society (DSD, 2013:9; DSD, 2005:7).

While both policy frameworks accentuate the equality of services to all people, special mention is made to the family as the central unit in communities and to the following groups labelled as “vulnerable”: children, youth, women, older persons, people with disabilities, and internally displaced people (DSD, 2013:31). Under the section of “Integrated Social Welfare Services” in these policy documents (DSD, 2013:28-31) the aspects of levels of service integration, levels of intervention, nature of services, and essential elements of the social welfare integrated service delivery model are indicated. These aspects are in summary depicted in Table 6.1 and practice guidelines relevant to these aspects are indicated.

Table 6.1: Aspects of Integrated Social Welfare Services as depicted in the ISDM for Developmental Social Services and the Framework for Social Services and suggestions regarding practice guidelines for psychosocial support to TSs presenting with an UP and/or TOP

Aspects of Integrated Social Welfare Services		Suggestions regarding practice guidelines based on the research findings and literature research
1. Levels of service integration	<p>The following levels of service integration are mentioned:</p> <ul style="list-style-type: none"> • Inter-sectoral and interdepartmental integration • Intradepartmental integration • Grassroots/Local service integration 	<p>In order to provide a holistic and comprehensive psychosocial support service to TSs presenting with an UP and/or TOP, interdepartmental and intradepartmental collaborations and partnerships between service units with tertiary institutions (student counselling and support, campus health services, and academic departments) (see Section 4.3.4.1, Category 4.1.1 – 4.1.3; Section 5.3.5.1; and Section 5.3.5.2, Category 5.2.1 – 5.2.3 for the participants' suggestions in this regard), governmental departments (DSD and Department of Health), and NGOs (such as the CPCC and other welfare organisations rendering child and family welfare services) are suggested.</p>
2. Levels of intervention	<p>Concerning the levels of intervention, the following are highlighted:</p> <ul style="list-style-type: none"> • Prevention • Early intervention • Statutory intervention • Reconstruction and aftercare 	<p>In view of preventing UPs and the trend of further UPs following a TOP, intra and interdepartmental (within the context of the university) prevention initiatives are suggested to promote safe sex practices and reproductive health (see Section 4.3.4.1, Category 4.1.2 and Section 5.3.5.1 for the participants' suggestions in this regard). Collaborations between tertiary institutions, governmental organisations, and NGOs at national, provincial and local levels must be forged to drive the mentioned prevention campaigns.</p> <p>In cases where foster care and adoption is chosen to manage the UP, tertiary institutions should have the information available on the social welfare SPs providing the statutory service in this regard and connect the TSs with these resources.</p> <p>For TSs continuing their studies following the UP and/or the TOP, support services within the university and partnerships and collaborations with support service organisation outside the university should be available to provide aftercare services (see Section 4.3.4.1, Category 4.1.1 – 4.1.3 and Section 5.3.5.1 for the participants' suggestions in this regard).</p>
3. Nature of services	<p>The nature of the services relates to the following:</p> <ul style="list-style-type: none"> • Promotion and prevention services and interventions 	<p>Apart from the promotion of prevention and interventions in this regard (already alluded to under levels of prevention), as well as the referral to social welfare service organisation in the case of foster care and adoptions, tertiary institutions have the social and moral responsibility to provide social support and therapeutic services (see</p>

	<ul style="list-style-type: none"> • Social assistance and relief services • Protection and statutory services • Social support services • Therapeutic, restorative, and rehabilitative services • Continuing care services • Reintegration and aftercare services • Economic development services 	<p>Section 4.3.4.1, Category 4.1.1 – 4.1.3; Section 5.3.5.1; and Section 5.3.5.2, Category 5.2.1 – 5.2.3 for the participants' suggestions in this regard) to students presenting with an UP and/or TOP (Kilander et al., 2018:104; Van Breda, 2011:20; 26; Burgen, 2010:29-30).</p> <p>In view of this, social support programmes are suggested and the formation of collaborate partnerships with other service departments within the university and in the community to provide such services (see Section 5.3.5.2, Category 5.2.1 for the participants' suggestions in this regard).</p> <p>In order for TSs to attain their educational goals following an UP and/or a TOP, tertiary institutions' academic, health, and student support departments should develop and present reintegration programmes and aftercare programmes/support for this purpose.</p>
4. Essential elements in the provision of integrated social welfare services	<p>The essential elements include the following:</p> <ul style="list-style-type: none"> • Assessment and profiling of service recipients • Intervention, which consists of the following elements: <ul style="list-style-type: none"> - Point of entry/Engagement (refers to where service recipients access support/social welfare services) - Screening and intake - Comprehensive assessment (inclusive of the development of a generic assessment tool to guide the assessment process) - Planning and implementation of the intervention (this is a joint process between the service recipient and provider, and should be based on the assessment). - Evaluation of intervention - Exit strategies - Referral of the service user - Termination of the services 	<p>For the provision of psychosocial support to TSs presenting with an UP and/or TOP, SPs should have the required education and training (or knowledge and skills-base) to –</p> <ul style="list-style-type: none"> • provide the correct information on the options to manage an UP with reference to keeping the baby after birth, foster care, adoption, and TOP. They should be comprehensively informed about the legalities surrounding TOP and the TOP-procedure, and they should be aware of the feelings and emotional reactions, as well as the behaviour manifestations following the student becoming aware of the UP and before and after the TOP. The SPs should also be familiar with the tertiary institution's policies, rules, and regulations regarding student pregnancies (see Section 5.3.6 for the SP-participants' suggestions in this regard). • establish a respecting and non-judgemental helping relationship, in which the TS will feel safe, especially as the experience of an UP conjures up feelings of guilt, shame, and fear of rejection (DSD, 2005; White Paper, 1997) (see Section 4.3.4.1, Category 4.1.1 and Section 5.3.5.1 for the participants' suggestions in this regard). • skilfully assess the situation surrounding the students' UP and/or TOP, the self of the TS as service user, her convoy of support (available and/or lacking), and the coping strategies available or required to arrest the situation. • plan interventions based on the assessment of the aspects mentioned. Such interventions should be in the best interests of the student, be appropriate, and be based on her unique/specific needs and circumstances. The interventions planned should recognise the student's right of ownership of her life and right to self-

	<p>offered.</p>	<p>determination. The interventions planned and implemented should aim to empower the student and encourage self-reliance. For this reason, individual strengths and capabilities should be recognised and utilised. Active participation of the student in all stages of the helping/intervention process should be encouraged and pursued (DSD, 2013:10; DSD, 2005:14).</p> <ul style="list-style-type: none"> • evaluate the intervention. • refer the TS to other social service organisation(s) offering services required by the student, falling outside the SP's scope of practice and to terminate the therapeutic relationship in a professional manner (see Section 5.3.5.2, Category 5.2.1 for the SP-participants' suggestions in this regard).
--	-----------------	--

Aside from the White Paper for Social Welfare (1997); the ISDM for Developmental Social Services (DSD, 2005) and the Framework for Social Services (DSD, 2013:27-35), the policies and legislation mentioned below inform the practice guidelines for psychosocial support to TSs presenting with an UP and/or TOP:

- The National Adolescent and Youth Health Policy 2017 (AYHP) (Department of Health, 2017);
- Family Planning Services: the National Adolescent Friendly Clinic Initiative (NAFCI) (Ashton, Dickson & Pleaner, 2009).
- The Choice on Termination of Pregnancy Act (CTOP) No 92 of 1996 (South Africa, 1996).

6.2.1 The National AYHP, 2017

Adolescent and youth participation stood central to the development of this policy, which advocates an integrated approach to adolescent and youth health with emphasis on the latter not only being problem-focused, but also on the promotion of healthy lifestyles and the mitigation of risk factors (Department of Health, 2017:1).

The purpose of the National AYHP is to provide guidance to departments, organisations, and SPs on how to respond to the health needs of young people. Its aim is to promote the health and wellbeing of young people between the ages of 10 and 24, thus aligning the Department of Health's (DoH) definition of 'adolescence' and 'youth' (elaborated upon in Section 1.5.9.1) (DoH, 2017:1) and with that of the World Health Organization (WHO, 2011:1). The National AYHP outlines several health challenges faced and identified by adolescents and the youth, of which sexual and reproductive health and unintended pregnancy, amongst others, have been identified as priorities. The importance of access to health services and the detrimental impact of lack of access thereto are emphasised and acknowledged by the policy. This lack of access to health and support services and/or the unavailability (actual or perceived) thereof, with specific reference to contraceptives, information (regarding UP-options, available resources, and the TOP procedure), and negative, judgemental attitudes from SPs have also been identified by the participants of this research study as barriers to service delivery (see Section

4.3.2.2, Category 3.2.2; Section 4.3.3.3, Category 3.3.1 – 3.3.4; Section 5.3.1.3, Category 1.3.2; and Section 5.3.4.2, Category 4.2.1 – 4.2.5). The literature consulted also identified and confirmed the mentioned aspects as obstacles and barriers to service delivery to TSs presenting with an UP and/or TOP (Grey, 2015:38; Adams & Williams, 2011:1880; Van Breda, 2011:24). The National AYHP suggests that the identified health priorities be addressed by interventions based on the developmental needs and active participation of adolescents/the youth.

The National AYHP makes provision for its implementation with strategic guidance from several role players, such as the DoH. Streamlining the key objectives of the policy (with specific reference to the use of innovative, youth-oriented programmes to promote the health and wellbeing of adolescents/the youth, as well as the provision of comprehensive, integrated sexual and reproductive health services) with adolescent and youth-friendly services is recommended. The latter, which refers to and includes family planning and healthcare services (see Section 4.3.4.1, Category 4.1.1 – 4.1.2; Section 5.3.5.1; and Section 5.3.5.2 for the participants' suggestions in this regard) also underpin the practice guidelines and are consequently introduced.

6.2.2 Family Planning Services: The NAFCI

Access to healthcare, particularly reproductive health, is a human right obligation which has resulted in a growing awareness of the importance of making health services more responsive to the needs of the youth. According to the WHO (2011), health services play an instrumental role in the sexual and reproductive health of the youth, more so when services are youth-friendly, in other words “accessible, acceptable, appropriate, effective and equitable”.

One of the earliest health interventions introduced by the democratic Government of South Africa was the provision of free healthcare, including contraception, at primary healthcare clinics. However, several factors related to the accessibility and acceptability of services, the negative and judgemental attitude of healthcare professionals, staff shortages, limited resources, as well as fear and shame associated with, amongst others, the experience of an UP or TOP (Sriranganathan, Jaworsky, Larkin, Campbell, Flynn, Janssen & Erlich, 2012:65; Miller, 2011:69)

resulted in these services being under-utilised (these factors were also confirmed by the research participants – see Section 4.3.1.3, 4.3.2.2, 4.3.2.3, 4.3.3.1 to 4.3.3.3, 5.3.1.3, and 5.3.4.2 in this regard).

The notion of youth-friendly health services originated from the conclusion reached by several role players, namely the Wits Reproductive Health and HIV Institute (WRHI) at the University of the Witwatersrand (WRHI, 2014) and the Chris Hani Baragwanath Hospital in Johannesburg in partnership with LoveLife (2012 & n.d.), that interventions targeting the sexual health of adolescents/the youth have to be supported by health services that accommodate the needs of these young people. In addition, the above-mentioned role players acknowledged that the public health sector is the most sustainable venue for providing health services that can reach out to many young people. Public health clinics were therefore identified as the vehicle for providing services to deal with sexual and reproductive matters relevant to the youth/adolescents.

The above-mentioned led to the coordination of the NAFCI. This programme was conceptualised and implemented between 1999 and 2005 and is a collaborative project between LoveLife, the WRHI, and the DoH. The aim of the NAFCI upon its establishment was to improve the quality of youth-friendly health services at the primary care level and to strengthen the public sector's ability to respond appropriately to the needs of adolescents/the youth (Ashton et al., 2009:9). This initiative has three key objectives, namely, to make health services accessible and acceptable to adolescents/the youth; to establish national standards and criteria for adolescent/youth healthcare in clinics throughout South Africa; and to build the capacity of healthcare workers in order to provide high-quality adolescent/youth healthcare. Informed by the findings of the research in this regard (see Section 4.3.4.1, 5.3.5.1, and 5.3.5.2 for the participants' suggestions) and in latching on to the objectives of the NAFCI, the importance of the following is emphasised:

- Tertiary institutions should embark on student-friendly drives to inform TSS about the health services available on campuses. Marketing of these services should portray a positive image of these services in order to ensure and enhance increased utilisation thereof.

- Tertiary institutions should ensure that they employ skilful healthcare practitioners committed to the provision of comprehensive, youth-friendly health services.

The NAFCI programme is based on quality improvement principles. Service provision is defined and guided by specific standards to ensure that health services are characterised by quality service delivery, based on the needs of adolescents/the youth and that barriers impacting on the utilisation of services are addressed and reduced (see Section 4.3.4.1, 5.3.5.1, and 5.3.5.2 for the participants' suggestions in this regard).

6.2.3 The CTOP Act No 92 of 1996 and the CTOP Amendment Act No 38 of 2004

The CTOP Act No 92 of 1996 was promulgated early in the transition to democracy in South Africa. One of the objectives of the Act was to reduce abortion-related morbidity and mortality, as well as to protect women's reproductive health choices and their rights to access to safe reproductive healthcare services (Harries, Gerdtz, Momberg & Greene Foster, 2015:1).

The CTOP Act No 92 of 1996 and the CTOP Amendment Act No 38 of 2004 promote reproductive rights and extend freedom of choice by affording every woman in South Africa, from the age of 12 years old, the right to choose whether to terminate her pregnancy before 12 weeks gestation. If she is between 13 and 20 weeks pregnant, she can request to have her pregnancy terminated if:

- her own physical or mental health is at stake;
- the baby will have severe mental or physical abnormalities;
- her pregnancy is the result of incest or rape; or
- she is of the personal opinion that her economic or social situation is sufficient reason for the termination of her pregnancy.

Should she be more than 20 weeks pregnant, her pregnancy can only be terminated if her life or the life of the foetus is in danger, or there are likely to be serious birth

defects. It is recommended that women under the age of 18 requesting TOP be advised to consult their parents/caregivers, but a woman can decide not to inform or consult them if she so chooses. A woman who is married or in a life partner relationship should likewise be advised to consult her partner, but again she can decide not to inform or consult him/her. The aforementioned however does not apply when a woman suffers from a mental illness or if she has been unconscious for a long time. In such cases the consent of a life partner, parent, or legal guardian is required (Harries et al., 2015:2; South Africa, 2005; Mhlanga, 2003:116; South Africa, 1996).

The CTOP Act No 92 of 1996 and the CTOP Amendment Act No 38 of 2004 further intend to ensure that TOP-services are available and accessible to all women in need thereof, thus promoting women's reproductive rights to have an "early, safe and legal abortion" (South Africa, 2005; South Africa, 1996). TOP-services are normally offered at approved healthcare facilities (such as government/state hospitals and primary healthcare clinics), officially designated by the Minister of Health (Harries et al., 2015:1; Trueman & Magwentshu, 2013:397).

In the Acts under discussion it is emphasised that the termination of a pregnancy should not be a form of contraception or population control. Provision is also made for non-compulsory counselling before, during, and after the TOP, aiming to assist women in making an informed decision (South Africa, 1996).

A medical practitioner generally performs the termination of a pregnancy, but a nurse may also perform the procedure, provided that she/he has received the appropriate specialised training. Nurses who have received TOP-training may perform terminations up to the 12th week of pregnancy. The mentioned training consists of values clarification workshops, the identification of an adequate amount of midwives and doctors for the provision of TOP-care, training in the different TOP-procedures, development of management guidelines, as well as training regarding contraception, including emergency contraception, as TOP has to be accompanied by contraception counselling and advice (Blanchard, Lince-Deroche, Feters, Devjee, De Mendes, Trueman, Sudhinaraset, Nkonko & Moodley, 2015:331).

Health workers are under no obligation to perform or take active part in the termination of a pregnancy if they do not wish to. They are however obligated by law to assist if it is required to save the life of the patient, even if the emergency is related to a TOP. Health workers who are approached by a woman for a TOP may decline if they choose to do so, but are obligated by law to inform the woman of her rights and refer her to another health worker or facility where she can have her pregnancy terminated (Blanchard et al., 2015:331; South Africa, 2005; South Africa, 1996).

Despite current legislation being perceived as liberal, it seems that the ability of the country to establish TOP-services is constrained by resources (in other words limited resources and reported staff shortages, also referred to in the introduction of the NAFCl above) (Ashton et al., 2009:44), the stigma attached to TOP, and negative attitudes toward and perceptions of TOP-services by healthcare providers, which is also confirmed by literature (Macleod et al., 2016:1097) and the research findings of this study (see Section 4.3.3.2, 4.3.3.3, and 5.3.4.2, Category 4.2.1 – 4.2.5). Policy and legislation stipulate that healthcare providers can choose not to work in TOP clinics (Macleod & Tracey, 2009:53). A severe discomfort with the fact that minors may obtain a TOP without parental consent has been expressed by many SPs employed at healthcare facilities that provide TOP-services (Blanchard et al., 2015:331), as well as concerning the fact that there is no restriction regarding the number of TOPs that a woman may request (South Africa, 1996; South Africa, 2005). Individual and religious bias against TOP exists among many healthcare professionals, with some of them supporting TOP conditionally, such as in the case of incest or rape, but opposing the consideration thereof for socio-economic reasons (Macleod & Tracey, 2009:54).

Reviews conducted by the DoH in this regard established that, despite a slight increase in functioning TOP-facilities (in other words, healthcare facilities designated by the Minister of Health for the provision of TOP-services) since 2003, the percentage of functioning service sites in 2007 were as low as 41% in some provinces (Macleod & Tracey, 2009:52). The mentioned statistics represent the percentage of officially designated sites and do not take into account other medical facilities equipped with basic theatre equipment sufficient to perform TOP-services,

provided that such facilities are registered with the DoH to do so (Macleod & Tracey, 2009:52). These findings are reiterated in the concerns of several women's health advocates who estimate that "less than half the abortion services supposed to be offered by government is operational" (IPAS, 2014).

The section on the policy frameworks and legislation underpinning the practice guidelines for psychosocial support to TSs presenting with an UP and/or a TOP is herewith concluded. In the next section, the practice guidelines for the provision of psychosocial support to TSs presenting with an UP and/or TOP will be presented.

6.3 PRACTICE GUIDELINES FOR PSYCHOSOCIAL SUPPORT TO TSs PRESENTING WITH AN UP AND/OR TOP

6.3.1 Introductory remarks

In the introduction to this chapter (see Section 6.1), I indicated that the literature and empirical research conducted for this research study informed the practice guidelines or the "how to" suggestions for the provision of psychosocial support to TSs presenting with an UP and/or TOP. I also indicated that the focus of the practice guidelines would be on suggestions for establishing a helping relationship with the TSs concerned and establishing "what to do" in terms of assessing and intervening in the aspects of the situation, the self, the support, and the (coping) strategies surrounding a TS's UP and/or TOP. As previously mentioned, the practice guidelines for the activities of assessment and intervention, which are informed by the equally essential elements in the provision of integrated social welfare services recommended by the Integrated Social Welfare Services as depicted in the ISDM for Developmental Social Services (DSD, 2005) and the Framework for Social Services (DSD, 2013:27-35) (see Table 6.1) during the provision of psychosocial support to TSs presenting with an UP and/or a TOP, are organised according to the 4S-system in Schlossberg's Transition Process Model, the adopted theoretical framework for this study.

In the next section the practice guidelines for establishing a therapeutic relationship in order to provide psychosocial support to TSs presenting with an UP and/TOP are offered.

6.3.2 Practice guidelines for establishing a therapeutic relationship with the TS presenting with an UP and/or TOP in order to provide psychosocial support

When a young, unmarried woman is confronted with an unintentional pregnancy, an array of feelings and emotional reactions are experienced. Some of the common feelings and emotional reactions experienced in this regard include feelings of shock, disbelief, stress, anger, shame, loneliness, and fear, as well as a tendency to withdraw and isolate herself (Barton et al., 2017; Akbarzadeh et al., 2016:190; Adams & Williams, 2011:1880). TS-participants in this study also expressed, confirmed, and elaborated on experiencing these feelings and reactions (see Section 4.3.1.3). The feelings of fear may be exacerbated by the possibility of being judged negatively by her peers and family, and also being isolated, deserted, or ostracised by them for presenting with an UP. Additionally, and upon disclosure of the UP, a young woman may lose her standing in her community; be removed from a leadership position she might have had in the tertiary institution community; and even be stigmatised as someone who is immoral and promiscuous (Akbarzadeh et al., 2016:191; Van Breda, 2011:22; Ekstrand et al., 2009:176-177; Skinner et al., 2009:52; Panday et al., 2009:27; Sekgobela, 2008:2; Naidoo & Kasiram, 2006:341). Such fear may also be present when reaching out for psychosocial support during the predicament of an UP and/or a TOP.

Against these introductory remarks the following practice guidelines are suggested in view of establishing a therapeutic/helping relationship with the TS presenting with an UP and/or a TOP, reaching out to a SP for psychosocial support:

- During the first engagement with the student, *the SP must create an environment conducive to service delivery* that is essentially safe, confidential, reliable, and consistent with appropriate and clear boundaries. It is suggested that the SP model and convey a welcoming, accepting, caring, comforting, and

non-judgemental attitude and portray an unconditional positive regard for and empathy with the student (Razzaque, Okoro & Wood, 2015:171; Roberts, Fenton & Barnard, 2015:32; Varcarolis, 2006:155).

- *The SP must actively pursue establishing a relationship with the student.* The following relationship-building skills are suggested:
 - Establish trust through displaying genuineness and empathy, developing positive regard, showing consistency, and offering assistance in alleviating the TS's emotional distress. Suggestions for establishing trust include that the SP introduces himself/herself to the student, refer to the student by name, and maintain eye contact with her. Although seemingly small, these gestures display an air of openness, friendliness, care, concern, and approachability, which can go a long way toward making the student presenting with an UP and/or TOP feel safe.
 - Convey respect for this student. This aspect refers to the ability of the SP to view the TS as worth caring about and as someone who has strengths and achievement potential. Respect is usually communicated indirectly by actions rather than directly by words. Of importance in this regard is respect for the student's boundaries, as well as respecting differences in personality and cultures.
 - Genuineness. This includes being open, honest, and sincere. The SP can accomplish this by building a rapport with the student, showing a genuine interest in her life and situation, and actively listening to her. Reflective and interpretative listening skills are seen as imperative, with the former including restatement, rephrasing and summary clarification and the latter including the identification of emotions and messages behind the student's words. This confirms the interest of the SP in the wellbeing of the student and offers reassurance that her concerns are being heard.
 - Acceptance. This should be done by exuding an unconditional positive regard for the student that transcends her personal qualities, beliefs, problems, situation, or crisis.
 - Empathy. This component is essential for the establishment of a therapeutic relationship. By way of reacting in an empathic fashion and through communicating an empathic understanding, the SP demonstrates

her understanding of the realities faced and the feelings and pressures experienced by the student presenting with an UP and/or TOP.

- Attending denotes the activity of being physically, intellectually, and emotionally present with the student and is one of the foundational elements in the helping relationship, as it assists with identifying and intervening in the way that the TS expresses herself in terms of thoughts, feelings, and behaviour. Characteristic attending behaviour includes establishing and maintaining contact with the TS and a positive body posture adopted by the SP (such as slightly leaning forward). However, the attending behaviour displayed by the SP needs to be sensitive and attuned to the cultural customs of the student (Razzaque et al., 2015:171-172; Roberts et al., 2015:32-33; Varcarolis, 2006:157-158).
- *The SP must formulate a collaborative relationship and a therapeutic contract founded on the following principles in order to lay the foundation for the provision of psychosocial support and to facilitate the process of adaptation to transition:*
 - Encouraging active participation of the student in all aspects of the intervention process pursued.
 - Acknowledging and encouraging the student to take ownership of her life and the decisions she makes, and to exercise her right to self-determination.
 - Acknowledging the student's individual strengths and capabilities and the utilisation thereof (All the mentioned aspects are entrenched principles in the White Paper of Social Welfare, 1997).

In summary, the SP should be cognisant of the fact that effective service delivery is characterised by both the SP and the recipient (student) taking joint responsibility for the process and recognising the potential and ability of the TS to actively participate in the process of working out ways of dealing with the UP and/or TOP-crisis.

- The bulk of the first contact or the phase where the student actively reaches out for help and, if needed, the follow-up contact must be devoted to *establishing a level of rapport, trust, and confidentiality conducive to the provision of psychosocial support*.
- The SP must, early in the therapeutic relationship (if not in session one, then in session two), *explore what prompted the TS to reach out for help and ascertain where she is in her journey of transition*. Is she “moving in, through or out of the transition?” (Anderson et al., 2012:38). *Moving in* may imply that the suspicion of her UP is confirmed and that she needs psychosocial support on how to manage this life transition. *Moving through* may be regarded as the time where an active decision has been taken on how to manage the UP, while *moving out* may denote the adaptation to the transition, continuing with her life, and pursuing her life goals.
- The SP must *be aware of the barriers that prevent TSs with an UP and/or a TOP from reaching out for help and psychosocial support*. The following were highlighted by the participants of this study (see Section 4.3.3.2, Category 3.2.2; Section 4.3.3.3, Category 3.3.1 – 3.3.5; and 5.3.4.2, Category 4.2.2 & 4.2.5) and the literature consulted (Coetzee & Ngunyulu, 2015:3; Grey, 2015:738; Van Breda, 2011:24):
 - Negative, judgemental attitudes and behaviour from SPs.
 - Language and cultural barriers.
 - Difficulty in accessing community resources.

In order to address the first barrier mentioned, SPs should consciously suspend value judgements and guard against using their own value systems to judge the student’s ideas, feelings, or behaviours. In the case where an UP resulted from engaging in high-risk sexual behaviour, the SP should accentuate the potential health risk of such behaviour for the student, but refrain from labelling her as being “bad” or “promiscuous” because of what has happened, which would cause her to feel stigmatised or even rejected.

Where the student decides on TOP as the option to deal with the UP, the SP should respect the decision without criticising or condemning it. The SP's role is rather to focus on and explore the factors influencing her decision in this regard, to provide information on what the TOP-procedure entails and the possible effect it might have on the TS.

SPs should exercise reflexivity and become consciously aware of how their presence, attitudes, and behaviour influence the helping process. They need to conduct introspection and uncover what lies at the root of their own feelings or bias. They need to use the skill of bracketing to keep at bay the negative attitudes and behaviours that are barriers to the provision of psychosocial support to TSs presenting with an UP and/or TOP. Where this is not possible, they are required to exercise a level of professionalism and refer the student to another SP.

Concerning the language and cultural barriers, it is suggested that the SP conduct the psychosocial support service, where possible, in a language that the student is comfortable with. This will convey a certain level of respect. SPs should use a language interpreter if necessary or refer the student to a SP that is familiar with the language of the student. Cultural barriers should be addressed by being aware of, sensitive to, and respectful of the cultural values and practices of the student. The SP should address harmful cultural beliefs and practices not in the best interest of the student (such as forced marriage) or infringing on the legislative framework.

SPs should, in addressing the barriers experienced by students attempting to access resources and support services, attempt to ensure that service locations are more easily accessible to students, with operating hours making it possible for students to utilise these services, as articulated by the research participants and as per their suggestions offered in this regard. SPs should attempt to ensure that service delivery facilities are characterised by a physical environment conducive to the provision of support and services (in other words a comfortable and private space for consultations) and sufficient supplies and equipment. SPs should furthermore, as suggested by the SP-participants (see

Section 5.3.6) receive relevant and appropriate training (specialised training related to the UP and TOP phenomenon) to provide quality services.

6.3.3 The purpose and focus of the psychosocial support provided to students presenting with an UP and/or TOP and the prerequisite knowledge base required by the SP

The purpose and the focus of the therapeutic relationship must be clearly delineated. As such the therapeutic engagement for the provision of psychosocial support may have one, more than one, or all of the following as its purpose/focus:

- *Facilitate the process of sharing of distressing thoughts and feelings*, as the occurrence of an UP and/or the experience of a TOP can leave the student feeling vulnerable, scared, and traumatised.

The SP's prerequisite knowledge on the feelings and emotional reactions that may be experienced by a student upon the confirmation of the UP / after a TOP
<p>In view of this, the SP must have prerequisite knowledge on the following feelings and emotional reactions that may manifest on confirmation of the UP (confirmed by literature and expressed by the research participants of this study) (see Section 4.3.1.3 and 5.3.2.1):</p> <ul style="list-style-type: none"> ❖ Feelings of shock, denial, disbelief (Akbarzadeh et al., 2016:190) expressed along the following lines: "This can't be true!" "I cannot believe it could happen to me... how could it happen to me?" and "It cannot be happening to me." ❖ Feelings of guilt and shame (Barton et al., 2017). This could come to the fore with utterances such as: "How could I let this happen?" and "What will my parents/partner/friends say?" ❖ Feelings of sadness, loneliness, and disappointment expressed, as well as crying (Barton et al., 2017; Akbarzadeh et al., 2016:192), along the following lines: "My life/dreams has come to an end." ❖ Feelings of anger. These feelings might be directed at herself and/or at

her partner (Barton et al., 2017).

- ❖ Feeling worried, stressed, and anxious (Barton et al., 2017): “What will/should I do?”, “How will this affect my studies/life/finances/relationships?”

The SP should also have prerequisite knowledge on the following feelings and emotional reactions that may manifest after the experience of a TOP (also confirmed by literature and expressed by the research participants of this study) (see 4.3.2.3 and 5.3.2.1):

- ❖ Feelings of sadness and grief, regret, anger, guilt, shame, loneliness, loss of confidence, isolation and/or withdrawal (Rocca et al., 2015; Bradshaw & Slade, 2013:930).
- ❖ Suffering from post-traumatic stress inclusive of psychological disturbances such as depression, anxiety, tearfulness, indecision, disturbed sleep, insomnia, nightmares, and flashbacks (Bradshaw & Slade, 2013:934).
- ❖ Behavioural disturbances which may include the following: avoiding babies, children and pregnant women; relationship problems; promiscuity; sexual coldness and avoidance of intimacy; physical tension; or wanting another baby (Bradshaw & Slade, 2013:934).

- *Assist the student with information on the options available to manage the UP and decision-making skills in order to make an informed decision on how to deal with the UP that occurred. Provide support and guidance (emotionally, practically, or instrumentally).* With reference to the decision-making skills, it is suggested that the SP introduce an exercise where the options for dealing with the UP are weighed in terms of pros and cons, and the assets and deficits in the situation, including the convoy of support and coping strategies, are all explored.

Knowledge required by the SP	
The SP must be adequately informed about the options of how the UP could be managed. The options are:	
Parenting	This decision tends to be influenced by the willingness of the TS's family or partner to support her and/or care for her child while she is completing her studies.
Adoption	<p>This option requires the consideration of the different types and forms of adoption, namely:</p> <ul style="list-style-type: none"> – <i>Public adoption</i> (the child is placed in the welfare system and the adoption is conducted through a government agency such as the DSD or through family welfare services or a NGO providing adoption services). – <i>Private adoption</i> (the adoption is conducted by a social worker in private practice or through private social service organisations specialising in adoptions). – <i>Kinship adoption</i> (an adoption agency or the birthparent(s) places the child with relatives). – <i>Open adoption</i> (this involves sharing of information between the adoptive and birth families throughout the child's life). – <i>Closed adoption</i> (all information relating to the child, the birth parents, and the adoptive parents remains confidential). – <i>Semi-open adoption</i> (some information and communication is allowed and shared through a mediator).
TOP	This option is described as a reliable indicator that the pregnancy is unwanted (Grey, 2014:1204).
<p>Where the student decides on TOP to deal with the UP, the SP should be well-informed about the –</p> <ul style="list-style-type: none"> ➤ legislation sanctioning this decision, specifically the CTOP Act No 92 of 1996 (South Africa, 1996) and the CTOP Amendment Act No 38 of 2004 (South Africa, 2005); 	

- medical procedures around the TOP-procedure and facilities sanctioned by law to conduct such procedures;
- post-abortion stress symptoms that can manifest as depression, tearfulness, indecision, disturbed sleep, nightmares, flashbacks, anger, self-punishment, loneliness, suicidal ideation or suicide, isolation and withdrawal from others, relationship problems, or promiscuity; and
- resources within the university, as well as within the community where students presenting with biopsychosocial problems falling outside the SP's scope and mandate of practice could be referred to.

If the student decides to carry the pregnancy to term, the SP needs to be up to date and well-informed about the university's policies concerning student pregnancy, especially if the student is utilising university-provided accommodation

Where the UP of the TS is managed by means of foster care and/or adoption, the SP needs to have a resource list available of the service organisations in the community offering such statutory services where the student can be referred.

- *Help the student to examine self-defeating behaviours and explore alternatives*

Knowledge required by the SP

The SP should have knowledge about self-defeating behaviours (such as people pleasing at the cost of the student's own wellbeing or happiness; or blaming others/not taking responsibility for the occurrence of her UP/TOP) (Tran & Rimes, 2017:144). The SP should make the student aware of defeating behaviour patterns by asking her to identify and reflect on negative and/or repetitive thoughts and behaviours (for example, by asking what behaviour the student tends to fall back on when faced with adversity or pressure and what defence mechanisms she utilises, such as denial or blaming). It is suggested that the SP introduce a behaviour diary to be kept by the student in which she can reflect on these negative thoughts, habits, behaviours, and possible triggers, as well as their consequences. In terms of exploring alternatives, the student should be encouraged to identify her

emotional needs and make a list of her strengths and coping skills with the purpose of identifying new, healthy behaviour patterns to replace the self-defeating behaviours and strategies to ensure that her needs are met. Emphasis should be placed on positive self-talk and thoughts.

- *Promote self-care and independence.*

Knowledge required by the SP

The SP should take cognisance of the fact that the student's self-care and independence, with specific reference to her decision-making abilities, might be negatively affected by the feelings and emotional reactions (presented above and confirmed by literature and the research participants) resulting from the experience of an UP and/or TOP. Aside from assisting the student with the decision-making process related to the UP, the following strategies to enhance self-care and independence (also suggested by the research participants of this study in Section 4.3.4 and 5.3.5) are suggested:

- the SP should encourage the student to take care of and accept responsibility for her emotional and physical health and wellbeing, by identifying her emotional needs and ensuring that these needs are met in a healthy way; and
- the SP should recommend regular exercise, medical check-ups, and counselling and/or a support group (Mlinac & Feng, 2016:506).

In summary, purpose and focus of psychosocial support for the TS with an UP and/or a TOP should be on –

- addressing the feelings, challenges, and pressures accompanying the experience of an UP and/or TOP;
- exploring the variables that might influence the decision regarding what to do about an UP;
- providing the required support, enabling the TS to make a calculated and informed decision on how to manage the UP; and
- providing the required social, medical, practical, and therapeutic support in and following the decision-making process.

Healthy adjustment to an UP or TOP therefore implies that support has been rendered in terms of the decision-making process, that the intense emotions that normally accompany the experience of an UP or TOP crisis have been effectively dealt with, and that a new sense of self-esteem and hope have been established (Grey, 2014:1201; Sereno et al., 2013:145).

6.3.4 Practice guidelines for conducting a biopsychosocial assessment of the student presenting with an UP and/or TOP

As alluded to earlier in this thesis, a TS's UP causes an upset in a steady state of affairs (Moos & Tsu, in Schlossberg, 1981:6), putting her in a transition. The transition is perceived as a time of crisis or a developmental adjustment, making the transition process one of pervasiveness to reorganisation (Anderson et al., 2012:39). Dealing with and adapting to transitions requires inner and outer work, confronting the losses and confusion associated with transition. Transitions require taking risks in the face of associated fears, and calls for strategies to move through (Anderson et al., 2012:56). As such, SPs should take note that this transition process, activated by an UP and/or the experience of a TOP, calls for the provision of psychosocial support that should allow for reflection and appraisal, exploration and assessment of the TS's circumstances, her inner strength to cope with and ability to manage her UP or TOP, the resources and support available to assist her, the coping mechanisms to be applied by her, and for interventions in this regard.

In the next section, an assessment tool will be presented (as practice guideline) to be used for the purpose of gathering biopsychosocial information about the TS presenting with an UP and/or TOP. This exploration and assessment covers the facets of the 4S-system in Schlossberg's Transition Process Model which are the situation, the self, the support, and the (coping) strategies, and set the stage for planning appropriate interventions.

After a therapeutic relationship has been established and a therapeutic contract has been drafted, the SP should embark on a journey of exploration to obtain a picture of the student's presenting problem, the circumstances surrounding it, her inner coping mechanisms, as well as the support she has to her avail in the situation. This

exploration will provide the ingredients for conducting an assessment of the aspects mentioned. A comprehensive assessment of the student presenting with an UP and/or TOP ensures the development of an appropriate intervention plan and is seen as critical in terms of effective service delivery.

Taking the suggestions offered by the ISDM for Developmental Social Services (DSD, 2005), and the Framework for Social Services (DSD, 2013:27-35) about assessment into consideration, SPs are alerted to the fact that assessment is a continuous process. It should be conducted at the onset of the helping process, throughout the process, and at the end in order to monitor and evaluate that the aims and outcomes identified for the helping process have been achieved. In addition, and against the developmental approach to social welfare services, assessment should focus on both the weaknesses and strengths of the student. The development and utilisation of a generic assessment tool for this purpose is therefore recommended.

In Table 6.2 on the following page an assessment tool for conducting a biopsychosocial functioning assessment of the TS presenting with an UP and/or TOP is suggested, inclusive of exploring and assessing the student's situation, self, support, and coping strategies (the 4S-system in Schlossberg's Transition Process Model).

Table 6.2: An assessment tool for exploring and appraising the biopsychosocial functioning and wellbeing of the TS presenting with an UP and/or TOP

BIOPSYCHOSOCIAL ASSESSMENT	
BIOGRAPHICAL INFORMATION Obtain the following biographical information about the student:	Name
	Date of birth
	Ethnicity
	Language
	Any other biographical information deemed necessary ...
PRESENTING PROBLEM Invite the student to describe in as detailed a manner as possible what brought her to come and see you as SP. (Refrain from using the word "problem". Instead of saying "what is the problem that brought you to come and see me?" rather say something like: "You came to see me, I am sure you have something on your mind that you would like to share with me, please tell me more about it"). Try and gather as much information as possible. Use requests such as: "please, tell me more..."; "help me to understand..."; and "Did I hear you correctly when you said...?". Try to get the sequence of events in terms of when, where, how and what.	
ANY CURRENT/PRESENTING ILLNESSES AND DISABILITIES Enquire whether the student suffers from any illnesses at present. Is the student disabled in any way?	
MEDICAL HISTORY Ask the student to tell you more about her medical history.	
CURRENT MEDICATION LIST Find out from the student if she is using any medication at the moment and what the medication is being used for.	
PSYCHIATRIC/PSYCHOLOGICAL HISTORY AND TREATMENTS RECEIVED IN THE PAST Find out from the student if she has suffered from any psychiatric or psychological conditions in the past; what, according to her, led to the onset of these conditions; and the treatments, if any, that she received for these conditions.	
INFORMATION ON THE UP AND/OR TOP The following questions can be directed at the student in order to gather information about when the UP became known/was confirmed and the physical symptoms associated with the occurrence thereof: <ul style="list-style-type: none"> • When did you find out about your UP? • How was your UP confirmed? • How far along were you in terms of your pregnancy at the time of confirmation? How far along are you now? • What were your initial feelings and emotional reactions about your UP? • What physical symptoms are you experiencing as a result of your pregnancy? • What emotions related to the pregnancy are you experiencing? Concerning the TOP, the following questions can be directed at the student to gather information: <ul style="list-style-type: none"> • Who performed the TOP and where was it done? • Did you go for counselling before the TOP and who provided the counselling? 	

- What were your thoughts and feelings before you went for the TOP?
- How did you feel after the TOP?
- What symptoms (physically and psychologically) did you experience after the TOP? What treatment did you receive for this, if any?
- Did you attend post-abortion counselling?
- How did the TOP change you as a person; your relationship with yourself, and the people close to you?

FAMILY OF ORIGIN AND SOCIAL HISTORY

Some of the questions for exploring and assessing the aspect of the family of origin was adopted from a family-of-origin exploration exercise developed by Alpaslan (1997:237-238):

- Tell me where you were born.
- How big is your family of origin?
- How many brothers and/or sisters do you have?
- Where do you fit in amongst your siblings? (Are you the eldest, youngest, middle, or only child?)
- Who raised you?
- Describe your relationship with your biological parents (or the person/s you regard as your parent/s). To whom are you the closest and why? Was this always the case? If not, what caused the change?
- Describe your relationship with your brothers and/or sisters. To whom are you the closest and why? Was this always the case? If not, what led to the change?
- What are the indications that the members of your family care about each other? What binds your family together? What drives them apart?
- Who has the most power in your family? Why do you think so?
- How does decision making take place in your family? Who is involved in the process?
- Describe your family's social, religious, political, occupational, and educational involvement and/or standing in the community.
- What types of loss, success, and pain have your family experienced? What was the effect of this on you and other family members?
- Explain to me how the members of your family would react when they hear, find out, or are informed about your UP and/or your TOP? Or, if they already know, how did they react upon hearing the news of your UP and/or TOP?
- How and in what way will their (or did their) reaction influence your decision on how to manage (or how you managed) your UP?
- On who will you be able to count for support with your UP and/or TOP?
- Who is currently supporting you now that they know about your UP and/or TOP? Who has rejected you since the information about your UP and/or TOP became known/public? How does this make you feel? What do you feel like doing in this regard?

EDUCATIONAL ASSESSMENT

Concerning the aspect of the educational assessment the following aspects need to be explored:

- The student's qualification enrolled for at the tertiary institution and her current year of study.
- The student's academic performance and progress. Is it satisfactory?
- The academic-related difficulties/pressures experienced by the student in general.
- The academic-related difficulties/pressures experienced since the confirmation of the UP/experience of the TOP.
- The student's educational goal(s) prior to and after the confirmation of the UP.
- How the student's attainment of her educational goals will influence her decision in terms of how to manage the UP.

DEVELOPMENTAL HISTORY AND ASSESSMENT OF CHILDHOOD AND CURRENT ABUSE

Ask the student to tell you about her childhood and growing up.

Explore whether the student had experienced any trauma, loss, or pain whilst growing up, how these traumatic experiences changed her life and life-course, and how she dealt with it.

Explore whether there is a history of abuse. Suggested questions for such exploration are:

- Have you experienced any physical, emotional, sexual, and/or economic abuse while growing up? If “yes”, tell me more about it...
- What happened? By who was the abuse perpetrated?
- How did this experience affect you as a person?
- How did you deal with the abuse that you experienced?

Explore whether any abuse is currently happening. Questions that could be asked in this regard are the following:

- Are you currently experiencing any physical, emotional, sexual, and/or economic abuse? If “yes”, tell me more about it...
- Who is abusing you?
- What do you think are the reasons for the abuse?
- How does this experience affect you as a person? How are you managing the abuse that you are currently experiencing?

ASSESSMENT – SEXUAL HISTORY

(Engagement in high-risk sexual activities; history about sexual health; previous UPs and/or TOPs and the aftermath thereof; and the current UP and/or TOP and its aftermath)

For the assessment of the student’s sexual history, engagement in high-risk sexual activities, history about sexual health, and previous and current UP and/or TOP and the aftermath thereof, the following questions are proposed:

- At what age did you become sexually active?
- Have you ever engaged in sexual activities that you would describe as high-risk? If so, tell me more about it.
- Have you ever contracted a sexually transmitted illness? If so, what type of illness did you contract? When and how did you contract it and what type of treatment, if any, did you receive for it?
- Have you experienced an UP before? What would you say were the reasons for the UP?
- What feelings did you experience when you found out about that pregnancy? How did you react?
- How did you deal with your previous UP?
- How did the way in which you dealt with your previous UP affect your life and life-course? In looking back at how you dealt with your pregnancy then, would you deal with it in the same way, if it had happened now?
- How did the previous UP and the way in which you dealt with it affect the relationship that you had with yourself? How have you as a person changed since then?
- How did the previous UP and the way in which you dealt with it change your relationships with the people close to you?
- What would you say are the reasons for your current UP/TOP... how/why did it happen? What feelings are you currently experiencing as a result of your UP/TOP? Have you given any thoughts about how you are planning to deal with your UP?
- How and in what way is your current UP/TOP going to change your life, your relationships, and your future?

- How is your current UP/TOP influencing your relationship with yourself?
- How do you think your current relationships with the people close to you are going to change when they find out about your UP/TOP, or now that they have found out about it... and when they find out about your plan to manage the UP, or how you managed it (for example, by TOP)?

FINANCIAL ASSESSMENT

For the purpose of conducting a financial assessment, the following questions/prompts are suggested:

- How would you describe your financial situation as a student in general?
- Who is paying for your studies? Who is supporting you financially while you are studying?
- What are the financial pressures that you, as a student, are currently experiencing?
- How do you think your UP will affect or change your financial situation?
- Now that your UP has been confirmed, what are your financial concerns, fears, and worries?
- When your sources of financial support find out about your UP and the way you plan to manage it, how will they react? Will they support or punish you?
- Have you given any thought to how you are going to survive financially now that you, as a student, are experiencing an UP?
- How... in what way... will your financial situation influence your decision on how to deal with your UP?

SPIRITUAL ASSESSMENT

The following questions are suggested for conducting a spiritual assessment:

- Would you describe yourself as a religious/spiritual person? If “yes”, tell me more about your religious/spiritual association and how you practice your religion/spirituality?
- How is the activity of sexual intercourse outside marriage viewed in your religion?
- How is an UP and/or a TOP regarded in your religion?
- How will/did the UP and/or TOP influence you religiously/spiritually? Did it estrange you from God or your spiritual source, or did it bring you closer to God/your spiritual source?
- How do you regard your religion/spirituality in this time of your UP and/or TOP? Is it a source of comfort or distress?
- Looking at your UP and/or TOP through your religious/spiritual glasses, how does it make you feel about yourself? What do think are God's/your spiritual source's thoughts about all of this?

CULTURAL ASSESSMENT

For the purpose of assessing the aspect of culture, the following questions could be utilised:

- What cultural group do you associate with?
- How is an UP and/or a TOP perceived in your culture?
- How will the way in which your cultural association views an UP and/or a TOP influence your decision in terms of the way you plan to manage your UP?
- What influence will an UP and/or a TOP have on your image, given your cultural association?
- How will your experience of an UP and/or TOP benefit/damage you and/or your family's standing within your community... and within your

culture?						
ASSESSMENT OF STUDENT'S ALCOHOL AND DRUG USE						
SUBSTANCE	Enquire whether the student is currently using any of the substances listed below.	Used in the past...	Method and amount of use	Frequency of use (times/day, or month)	Approximate date when student started using these substances and duration of use	Does the student perceive the use to be a problem? (Yes/No)
Nicotine						
Caffeine						
Alcohol						
Marijuana						
Heroin						
Cocaine / crack						
Methamphetamines (a stimulant usually used in powder or pill form, commonly referred to as "crystal-meth", "ice", or "speed")						
Hallucinogens (mood and perception altering drugs inclusive of LSD, referred to as "acid" or "microdots"; Ketamine, referred to as "K"; and PCP, referred to as "rocket".						
Stimulants (referred to as "uppers", inclusive of prescription medications such as Ritalin)						
Inhalants (includes solvents such as paint thinners, aerosols, and gasses such as chloroform)						

Other (specify)					
<p>Enquire whether the student's substance use started/changed since the confirmation of the UP and or prior to/or after the TOP. What are the student's reasons for using the substances? (What must it help with?)</p>					
<p align="center">MENTAL HEALTH ASSESSMENT</p> <p>In assessing the aspects below, the SP should take note of any relation between these aspects/current concerns and the student's past psychiatric/psychological history (explored above). Any other/additional concerns should be noted and a decision taken on whether a referral (for example to a medical doctor, hospital, or a psychiatrist) is needed.</p>					
<p>STUDENT'S BEHAVIOUR How would you describe the student's behaviour? Has there been a change in her behaviour since the experience of her UP/TOP?</p>	Normal Agitated Restless Lethargic Tremors Tics Other:	<p>STUDENT'S ATTITUDE How would you describe the student's current attitude towards her significant others, fellow students, friends, family, her studies... Has there been a change in her attitude since the experience of her UP/TOP?</p>	Hostile Suspicious Cooperative Guarded Stubborn Negative Other:		
<p>STUDENT'S GROOMING AND GENERAL DEMEANOUR How would you describe the student's appearance? Has there been a change in her appearance since the experience of her UP/TOP?</p>	Well-groomed Good eye contact Poor eye contact Dishevelled Inappropriately dressed Poor hygiene Other:	<p>STUDENT'S MOOD How would you describe the student's general mood? Has there been a change in her mood since the experience of her UP/TOP?</p>	Normal Depressed Anxious Irritable Indifferent Euphoric Other:		
<p>STUDENT'S CURRENT THOUGHT CONTENT AND PROCESS Assess the student's thought processes. Has there been a change in her thought content and process since the experience of her UP/TOP?</p>	Normal/Intact Concrete thinking Loose associations Inability to think abstractly Preoccupied Other:	<p>STUDENT'S ABILITY TO FOCUS AND CONCENTRATE Is the student able to focus and concentrate on her studies? Has there been a change in her ability to focus and concentrate since the experience of her UP/TOP?</p>	Normal (able to apply strategies to focus and concentrate) Unable to focus and concentrate (experiencing intrusive thoughts or her mind wanders) Other:		
<p align="center">PREVIOUS SUICIDAL ATTEMPTS AND CURRENT HOMICIDAL IDEATION</p> <p>Explore and assess the following:</p> <ul style="list-style-type: none"> Has the student attempted suicide before? What led her to attempting suicide? Is the student's homicidal ideation so serious that institutionalised treatment is required? 					

<ul style="list-style-type: none"> • Did the student want to attempt or has she attempted suicide upon confirmation of the UP and/or before or after the TOP? What, apart from the UP and/or TOP prompted such behaviour? How was the attempted suicide executed? Who came to her rescue and what treatment did the student receive, if any? • Is the student at risk of attempting suicide now? Has she made any references or suggestions to suicide, plans to commit suicide, or a homicidal ideation? Is the student currently posing a danger to others? Who does she want to harm, and what does she want to do to them? (Be on the lookout for any disclosures in this regard.) • Are there any high-risk and self-injurious behaviours present, such as cutting herself, eating disorders, excessive alcohol and/or drug use, high-risk sexual activities (multiple sex partners and unprotected sex)? 	
<p style="text-align: center;">FAMILY HISTORY OF MENTAL ILLNESS</p> <p>Questions for exploring and assessing these aspects are:</p> <ul style="list-style-type: none"> • Has any relative in the family of origin ever suffered from a mental illness? • What type of mental illness did they suffer from? Was treatment/hospitalisation received? 	
<p style="text-align: center;">STUDENT'S WAYS OF COPING WITH STRESS AND CURRENT WAYS OF COPING WITH THE UP AND/OR TOP</p> <p>The following questions are proposed to explore and assess this aspect:</p> <ul style="list-style-type: none"> • How do you normally cope when you are under stress? What do you do? How do you react? • How does the way in which you deal with stressful situations make you feel about yourself? How does it influence your relationship with yourself? • How does the way in which you manage stress affect and influence your relationships with the people close to/around you? • How would you describe your current way of coping with the UP and/or TOP? Does this way of coping influence your relationship with yourself or others? If so, in what way? • What made you choose this way of coping... who/what influenced you to cope in this way? <p style="text-align: center;">Based on the information given by the student, decide whether the coping strategies used are adaptive or maladaptive.</p>	
<p style="text-align: center;">Adaptive coping</p> <p>(To what extent does the student apply adaptive coping strategies or attempt to deal with her UP/TOP in a healthy, constructive way? What strategies are being applied in this regard, such as stress management techniques, attending counselling, and so forth?)</p>	<p style="text-align: center;">Maladaptive coping</p> <p>(To what extent does the student apply negative behaviours/strategies in order to cope with her UP/TOP, for example self-harming behaviour, defence mechanisms such as denial or blaming, or substance abuse?)</p>
<p>Based on the exploration, the information gathered:</p> <ul style="list-style-type: none"> • Indicate areas of concern, prioritising it accordingly to set an intervention agenda co-consulted and constructed with the student. • Write an assessment statement on the functional ability of the student. 	

6.3.5 Practice guidelines to intervene in the presentation of an UP

An unmarried student experiencing an UP finds herself in the midst of a multifaceted crisis for which she has to find a solution as soon as possible (Grey, 2015:737). For this reason, the Six-Step Model of Crisis Intervention, developed by James and Gilliland (2012:13) (illustrated in Table 6.3) was adopted and adapted and is presented as part of the practice guidelines.

6.3.5.1 The Six-Step Model of Crisis Intervention as practice guideline to intervene in the presentation of an UP

This model proposes six steps as well as an assessment system, known as the Triage Assessment System (TAS) for crisis intervention (Myer, Williams, Ottens & Schmidt, 1991 & 1992, in James & Gilliland, 2012:59). The first three steps relate to listening while the last three steps are related to action behaviours on the part of the SP. The suggested utilisation thereof in intervening in the presentation of an UP is presented in Table 6.3.

Table 6.3: The Six-Step Model of Crisis Intervention

ASSESSING

Overarching, continuous, and dynamically ongoing throughout the crisis, evaluate the client's present and past situational crises in terms of her ability to cope, personal threat, mobility or immobility, and make a judgement regarding type of action needed by the crisis worker (refer to action continuum below)

Listening ↓	Acting ↓
<p>LISTENING attentively, while observing both the verbal and non-verbal behaviour and responding with empathy, genuineness, respect, acceptance, non-judgement, and care to pursue the following aims:</p> <ol style="list-style-type: none"> 1. Defining/assessing the problem/crisis – depart from the student's point of view. 2. Ensure the student's safety. Assess the seriousness of threat (the UP) to the student's physical and psychological safety; assess the student's internal thought processes and the situation surrounding her; and ensure that the student is made aware of alternatives to impulsive/self-destructive actions. 3. Provide support. Communicate to the student that you as SP are a valid support person. 	<p>ACTING: Becoming involved in the intervention at a nondirective, collaborative, or directive level, depending on the student's mobility, partial mobility, or immobility, and according to the assessed needs of the student and the availability of environmental supports:</p> <ol style="list-style-type: none"> 4. Examine alternatives. Assist the student in exploring the choices she has available to her now. Facilitate a search for immediate situational, intrapersonal, and interpersonal supports, coping mechanisms, and positive thinking. 5. Make plans. Assist the student in developing a realistic short-term plan that identifies additional resources and provides coping mechanisms. Formulate definite action steps that the student can own and comprehend. 6. Obtain commitment. Help the student to commit herself to definite positive action steps that she can own and realistically accomplish or accept.

- **Step 1:** Defining the crisis and the extent/severity thereof. The SP should guide the student to inform her about the crisis she is experiencing and why it constitutes as a crisis.
- **Step 2:** Ensuring the safety of the student. Determine if the crisis (the UP) is a threat to the student physically and/or psychologically and/or if she is a danger to herself. Establish whether the UP-crisis causes her to be in danger by being harmed by a partner and/or family member(s) who do not approve of the UP. Where the latter is a reality, measures must be put in place to ensure the student's physical safety. Where destructive and impulsive behaviour threats are made, the student should be furnished with alternatives, after the essence of the former has been explored.

- *Step 3: Providing support in terms of displaying a caring, non-judgemental, and accepting attitude towards the student in spite of the UP-crisis and the emotional turmoil and instability experienced as a result of it.*

The questions below (adopted and adapted from the TAS of Myer et al. in James & Gilliland, 2012:59) can be utilised to “listen” to and assess the affective, cognitive, and behavioural functioning of the student during the crisis experienced:

- *Questions to assess the level of affective functioning/dysfunctioning of the student:*
 - “What emotion(s) are you experiencing in response to/as a result of your crisis situation?” (in the case where the student is immobilised by her UP-crisis, the SP can suggest specific emotions, such as sadness, fear, anxiety, or anger).
 - “On a scale from one to five, please rate your experience and perception of the intensity of the emotion” (with five, for example, referring to an emotion that is overwhelmingly negative, intense and out of control; and one indicating a stable mood with appropriate emotional experience and expression).
- *Questions to assess the level of behavioural functioning/dysfunctioning of the student:*
 - “Please describe which behaviour is being used to cope in reaction to the crisis situation that you are currently experiencing?” (Once again, where the crisis has immobilised the student, the SP can suggest specific coping behaviours applied or not applied, such as avoidance, appropriately performing tasks necessary for daily functioning, or neglecting to do so).
 - “On a scale from one to five, please rate your perception of the intensity of your reaction” (with five referring to a severe impairment in behaviour, for example the utilisation of avoidant behaviour to such an extent that she isolates herself completely from others, misses classes and tests, and puts her studies in jeopardy as a result thereof; and one referring to appropriate coping mechanisms, for example still interacting with her significant others and meeting her academic demands, despite the occurrence of her UP).

- *Questions to assess the cognitive function/dysfunctioning of the student:*
 - “Please identify and describe your cognitive reaction to your crisis situation” (once again where the crisis has immobilised the student, the SP can enquire whether the crisis makes it difficult for her to concentrate, focus, or think clearly, and whether she is able to solve the crisis, think of alternatives about how to solve the problem, and make a decision in this regard).
 - “On a scale from one to five, please rate the level of your cognitive functioning” (with five referring to severe impairment, for example an inability to concentrate and focus or think about anything except the crisis event; and one referring to concentration, problem solving, and decision-making abilities that are in-tact).

In order to alleviate and intervene in the UP-crisis, and depending on the student’s level of mobility, the SP can become directly, partially, or indirectly involved in the process of arresting the crisis by implementing the *last three steps* of the **Six-Step Model of Crisis Intervention** (James & Gilliland, 2012:50), as depicted in Table 6.3 above and elaborated on next.

- *Step 4: Exploring alternatives.* In terms of the UP-crisis experienced, this entails an exploration by the student and the SP of the alternatives available to address the UP. The options available regarding the UP (namely parenting, adoption, foster care, or TOP) must be explored in terms of pros and cons given the student’s current situation and her future, as well as her current relationship with her partner and her family. The SP should also assist with facilitating a search for an immediate interpersonal convoy of support, as well as institutional support by asking herself: “Where can you go to for help and support and/or who can you call on, or should I assist you to call on someone for help?” In addition, destructive thinking patterns need to be challenged and replaced by positive and encouraging thoughts. The same applies to replacing negative coping mechanisms with actions and goal-directed coping mechanisms that will address the crisis experienced in order to make it more manageable.

- *Step 5: Planning action steps* (the SP assists the student in developing a realistic, short-term plan that identifies additional resources and provides coping mechanisms). In terms of the UP-crisis this would relate to the SP assisting the student to make an informed decision, based on their exploration of the different UP-options. Guidance, assistance, and support with regard to the option chosen should be provided (for example, if the student chooses to terminate her UP, the SP should assist with an appropriate referral in this regard. The attendance of pre and post-abortion counselling, and utilisation of other resources, such as medical support and follow-up, academic support, enlisting the support of her significant others, and/or joining a support group, should be recommended and encouraged).
- *Step 6: Making a commitment* (the SP helps the student to commit herself to definite actions steps that she can own and realistically accomplish). In terms of the UP-crisis this would relate to the SP assisting the student to deal with and come to terms with the decision that she has taken. If the student, for example, chose single parenting, the SP and student should identify strategies to assist the student in coping with this decision (by identifying action steps and goals that are realistic and obtainable). This should include strategies to cope with academic demands as well as the demands of being a single parent. Utilisation of appropriate resources and support systems should be encouraged (such as enlisting the practical support of significant others to assist with taking care of the baby when the student is writing exams). The SP should provide unconditional acceptance, despite the decision taken by the student as well as continuous encouragement, support, and monitoring to ensure that the identified goals are achieved.

In this Six-Step Model of Crisis Intervention (James & Gilliland, 2012:50), the counselling can range from nondirective to directive. This is elaborated on next:

- ✓ **Nondirective counselling:** this approach is appropriate when the student is able to initiate and carry out her own action steps. It implies that she owns the problem, adaptive coping mechanisms are being utilised, the action plan is clear, and she is committed to see it through to the end. In this context the SP,

being the support person, listens, encourages, reflects, reinforces, and suggests. Nondirective counselling assists the student in mobilising what is already inside her, namely the capacity, ability, and coping strength to solve her own problems in ways that are already known to her, but are temporarily out of reach.

- ✓ Collaborative counselling: this approach allows the SP to evaluate the problem in collaboration with the student, create acceptable alternatives, and to plan and implement realistic and achievable action steps. Collaborative counselling is particularly appropriate when the assessment indicates that the student cannot function successfully in a nondirective mode, but has enough mobility to be a partner in the crisis intervention process. The collaborative client is not as self-reliant and independent as the fully mobile client, but does have enough ego-strength and mobility to participate in resolving the problem.
- ✓ Directive counselling: this approach is necessary when the student is assessed as being too immobile to cope with the current crisis. This implies that the SP is the primary definer of the problem, seeker of alternatives, and developer of an adequate plan. The SP furthermore instructs, leads, or guides the student in the action and, by taking a very directive stance, takes control, authority, and responsibility for the situation.

In addition to the Six-Step Model of Crisis Intervention (developed by James and Gilliland, 2012:50), I also want to offer the Six Steps to Crisis Intervention (in an adapted format) suggested by Philkill and Walsh (2002) in their *“Equipped to Serve (ETS) – Caring for women in crisis pregnancies”* programme as part of the practice guidelines proposed. This programme is a specialised training programme, developed to train volunteer counsellors at CPCCs worldwide, with the purpose of offering crisis pregnancy counselling to women presenting with an UP.

6.3.5.2 *The ETS programme as practice guideline to intervene in the presentation of an UP*

The suggested utilisation of the six steps, adopted and adapted from the ETS programme (Philkill & Walsh, 2002), is as follows:

- *Step One* is devoted to establishing a helping relationship with the student presenting with the UP, as the cementing of such a relationship paves the way for exploring and guiding the student experiencing the UP-crisis.
- *Step Two* aims to reduce the anxiety that the student might be experiencing by way of validating her emotions whilst she shares her experiences.
- *Step Three* focuses on the issues related to the UP-crisis, such as the student's context and circumstances, her emotions, and the pressures experienced as a result of the UP, as well as support she can draw on during this crisis situation.
- In *Step Four* the SP assists with appraising the resources available to the student in terms of her significant others, community resources, and her own capacities and strengths that could be mobilised to address the UP-crisis.
- In *Step Five* the SP assists and encourages the student to develop a plan of action that includes concrete goals on the management of the crisis experienced in relation to the UP.
- In *Step Six* the SP obtains permission from the student to follow-up with her by means of another appointment or a phone call with the purpose of reflecting on the decision made by the student or additional support needed.

The authors of the ETS programme suggest that the process of offering support and assistance to the woman confronted with a crisis pregnancy should be brief, not lasting for more than a few weeks, consisting of two to six sessions/consultations, depending on the immediate needs of the client (Philkill & Walsh, 2002). This suggestion is in line with the general aim and priority of crisis intervention, namely to provide immediate and short-term support and care with the purpose of assisting the individual in a crisis situation to restore equilibrium to the individual's biopsychosocial functioning and to minimise the potential of long-term psychological trauma (Rodda, Lubman, Cheetam, Dowling & Jackson, 2015:117). It is emphasised that crisis intervention is a time-limited process aiming to minimise the stress of the event (the occurrence of an UP), provide emotional support, and improve the individual's coping strategies in the here and now.

6.3.5.3 *Practice guidelines for revisiting the circumstances leading up to, and the feelings and emotional reactions following the UP-experience*

For the intervention aimed at guiding the TS to revisit the circumstances (which refers to the facet of the ***Situation*** in Schlossberg's Transition Process Model) (Schlossberg, 2011:160; 1981:8) leading up to the UP and her feelings and emotional reactions following this event, as well as how the feelings and emotional reactions experienced could be managed in a constructive fashion so as to not jeopardise her relationship with herself or the significant others in her life, the following guideline (inclusive of functional aids⁴⁸ and a homework assignment) is suggested for intervention:

- ***A collage exercise for depicting the circumstances that led to the student's UP and the resultant feelings and emotional reactions experienced:***

Ask the student to, as part of a homework assignment, make a collage by using objects, pictures from a magazine, or by drawing the events that, according to her, led to the occurrence of her UP. Her collage should depict her perception of the reasons for the occurrence of her UP, as well as her experience thereof, namely the feelings and emotional reactions following her UP. If she struggles to depict her feelings and emotional reactions in her collage, she can list it separately.

The SP needs to emphasise that the student has free range in putting the collage together; that it could be any size and that there is no restriction on the material she is allowed to use. In addition, the SP should reiterate that the collage (inclusive of pictures used, drawings made, and words and phrases used, especially to depict the feelings and emotional reactions experienced) need not be "perfect" or a "work of art", as the purpose thereof is to provide the student with an opportunity to reflect and think about what led to her UP and the

⁴⁸ Functional aids are activities, techniques, or structured experiences that can be utilised in order to assist the SP in achieving the goals set for an intervention with the ultimate purpose of creating insight and encouraging behavioural change (Du Preez & Alpaslan, 1992:19-20). The functional aids suggested in these practice guidelines are focused on assisting SPs in their service delivery to TSs presenting with an UP and/or TOP.

feelings and emotional reactions experienced as a result. This will also allow the SP “to get the picture” when the collage is presented and to further explore the occurrence of the event in a follow-up session. A further aim with this exercise is to enhance the student’s insight into the circumstances that led to the UP, help with the identification of feelings, and to, as part of the intervention, provide pointers and suggestions on how to manage the feelings experienced in a constructive way.

In the follow-up session, the student is requested to present her collage. The SP can intersperse this presentation by asking further probing questions and/or requesting clarification of the information shared in order to obtain a complete and comprehensive picture of the student’s situation.

Concerning the feelings and emotional reactions shared, the SP can affirm that these are common and normal given the UP experienced. Particular attention should be devoted to asking the student about how she expresses her feelings and emotional reactions and to reflect on how this affects her relationship with herself and her significant others. Where the expression of feelings is harmful to the self and others, the SP can offer suggestions, for example: instead of (unfairly) lashing out at her partner to vent her anger about the UP, she could rather hit a punching bag to vent her anger in a constructive way.

The collage representing the story of the student’s UP and the feelings and emotional reactions experienced as a result of it can, upon completion of this exercise, be stored safely and revisited at the end of the student’s process with the purpose of making another collage/list, reflecting on her transition (the outcome thereof, what she did to address and adapt to the transition) and comparing it with her first collage in order to reflect on her growth and adjustment.

6.3.5.4 *Practice guidelines for appraising and enhancing the psychosocial competence of the TS in the decision-making process regarding her UP*

The inner strength of the TS to cope with her situation and to manage and adapt to her UP (with specific reference to the decision-making process, as this aspect is central in her transition to adaptation) relates to her perceived or actual appraisal of assets and/or liabilities which tie in with/are assessed with reference to the facet of the **Self** in Schlossberg's Transition Process Model (Schlossberg, 2011:160). In the context of the guidelines this would refer to the psychosocial competence of the TS presenting with an UP, which finds expression in attitudes about oneself, the world, and behaviour. Adapting to the UP-crisis is, in this regard, determined by:

- a self-attitude characterised by a positive self-evaluation/esteem, a sense of self-worth and responsibility, as well as an internal locus of control;
- world attitudes, characterised by traits of hope, optimism, and trust; and
- behavioural attitudes such as demonstrating initiative, the ability to set and achieve goals, as well as the display of an active coping disposition (Tyler, in Schlossberg, 1981:13).

a) Practice guidelines for assessing the student's self-esteem

The experience of an UP may cause the self-esteem⁴⁹ of the TS to suffer, which might impact negatively on her coping abilities (Barton et al., 2017; Moore et al., 2017:108; Biggs, Upadhyay, Steinberg & Foster, 2014:2512; Bradshaw & Slade, 2013:930).

For this reason, and as part of the practice guidelines offered, I want to suggest that the student's current level of self-esteem be appraised. Self-esteem refers to a positive or negative orientation toward oneself; an overall evaluation of one's worth, abilities or value (Stets & Burke, 2014:409). According to Rosenberg (1965:31), self-

⁴⁹ Several authors (Biggs et al., 2014:2512; Warren, Harvey & Henderson, 2010:231) concur that low self-esteem and/or negative self-concept does not seem to be associated with the experience of a TOP. The mentioned authors state that the strongest predictor of low self-esteem in this regard is the measure of any prior presence thereof. Although the purpose of the practice guidelines offered in this section are to assess and intervene in the presentation of an UP, it can, should the SP deem it necessary or appropriate, also be utilised for assessing and intervening in the self-esteem and -concept of the student presenting with a TOP. Guidelines for assessing and intervening in the presentation of a TOP are presented later in this chapter (see Section 6.3.6).

esteem is only one component of the self-concept, which he defines as the "totality of the individual's thoughts and feelings with reference to himself as an object".

I have consequently adopted and adapted the Rosenberg Self-esteem (RSE) Scale (Rosenberg, 1965) for this purpose, as can be comprehended, completed, scored, and interpreted by the SP with relative ease. This scale comprises 10 items relating to a person's general appraisal of himself or herself. When requesting the student to complete the RSE, the SP must explain that she must respond to each item on the scale. Where she "strongly agrees" with a statement she must mark the "4" next to the statement, and if she "agrees" with a statement she must mark a "3". In the case of disagreeing with a statement, she can mark a "2", and if she "strongly disagrees" the number "1" option must be marked.

+Scoring: Note to the SP: Statements 2, 5, 6, 8 & 9 in the RSE scale are negatively phrased and the scores provided by the student needs to be reversed. For example: a 1 becomes a 4; a 3 becomes a 2; a 2 becomes a 3, and a 4 becomes a 1. Add all numbers to all the statements after reversing the scores as per statements 2, 5, 6, 8 & 9.

Interpretation:

A score between 10 and 20 denotes a positive self-esteem

A score between 21 and 40 denotes a negative self-esteem

Table 6.4: The RSE Scale (adopted and adapted for the guidelines)

Question		Tick the appropriate answer			
		Strongly Agree	Agree	Disagree	Strongly disagree
1	I generally feel happy and content with myself	4	3	2	1
2	There are times when I feel that I have no purpose	4	3	2	1
3	I am as capable as the people around me	4	3	2	1
4	I have several positive qualities	4	3	2	1
5	I have little to be proud of	4	3	2	1
6	There are times when I feel useless	4	3	2	1
7	I feel worthy	4	3	2	1
8	I want to have more respect for myself (reverse scoring)	4	3	2	1
9	I feel like a failure	4	3	2	1
10	I feel good about myself	4	3	2	1
Score					

- b) Practice guidelines for assessing the student's appraisal of the comprising parts of the self-concept

As the construct **self-concept** comprises the physical, intellectual, psychological, social, moral, gender, and ideal self (Alpaslan, 1997:32), I have adopted and adapted Alpaslan's Synoptic Self-esteem Framework (Alpaslan, 1997:165) to assess how the student views the comprising part of the self-concept.

It is suggested in this regard that a list containing the following questions be provided to the student, requesting her to respond with a "yes" or "no" answer to each of the questions.

Table 6.5: Alpaslan's (1997:165) Synoptic Self-Assessment Framework (adopted and adapted for the guidelines)

THE ADAPTED VERSION OF THE ALPASLAN'S (1997:165) SYNOPTIC SELF-ASSESSMENT FRAMEWORK
<ul style="list-style-type: none">• Are you content and pleased with your physical appearance?• Are you content and pleased with your intellectual capabilities?• Are you content and pleased with your personality and temperament?• Do people generally like you?• Do you think that people think that you are a pleasant person?• Are you able to forgive yourself when you make a mistake?• Are you content and comfortable with being a female?• Are you able to achieve the goals you have set for yourself?• Do you think you have potential?• Do you enjoy spending time with other people?• Is it important for you to do the right thing in order to gain approval and acceptance from others?• Are you comfortable with being who you are?• Do you have aspirations and dreams?

Note to the SP: Where the student answered “yes” to a particular question, it points to being positive about this aspect of the self-concept. A “no” answer is indicative of the fact that the student feels negative about this aspect.

All answers, but especially the negative answers, should be further explored to determine whether the negative answers are related to the experience of the UP.

Negative appraisals of the self-esteem and/or self-concept should be explored with the purpose of determining the underlying reason for it. The SP should aim to guide the student to accept the aspects of her self-concept that she has no control over (in other words, physical traits such as the colour of her eyes or skin) and to encourage her to work on the aspects that she can change (Alpaslan, 2018:315). For example: where an inability to forgive herself is experienced in terms of making a mistake, such as presenting with an unintended pregnancy, the SP needs to, with sensitivity, point out how an attitude of unforgiveness towards oneself could hamper the process of adaptation to transition.

*In further pursuit of assisting the student towards a positive appraisal of herself, the SP could, in the case where a negative appraisal was made (based on the questions in the **Synoptic Assessment Framework** above), ask the following questions:*

- What are the reasons for your discontentment and not being pleased with your physical appearance, intellectual abilities, personality and/or temperament? Realistically, which of these aspects can be changed, how can it be changed, and which do you have to accept and embrace?
- How did you come to the conclusion that people in general do not like you and do not think of you as a pleasant person? What are the reasons for you not liking to spend time with people? What do you think could be done? How could this be changed?
- How did you get to the conclusion that you are not able to achieve the goals that you have set for yourself? How should this be changed, and what are you willing to do in this regard?
- What led you to arrive at the conclusion that you do not have any dreams and aspirations? How can this script be changed?

- It seems that doing the right thing to get the approval from others and being accepted by them is important to you. How does not meeting this expectation make you feel about yourself?
- What are your reasons for not being content and comfortable with being a female? How does this hinder you from acquiring a positive self-esteem?

- c) Practice guidelines for encouraging self-reflection in view of enhancing and/or maintaining a positive self-appraisal

Where the student obtained a negative score on the RSE scale, and appraised some of the comprising parts of her self-concept negatively, the SP can, as part of the intervention strategy to enhance the self-concept and self-esteem of the student, introduce an exercise in the form of a **Self-Esteem Journal**, inviting the student to honestly reflect on and write down aspects that make her feel proud and positive, or the feedback from significant others generating similar feelings. Requesting the student to engage in introspection on a daily basis and writing down at least one or two of the positives about herself on this journey of self-discovery will lead to developing a more positive and realistic appraisal of herself.

The example of the Self-Esteem Journal (provided) containing the positive open-ended statements below can be utilised to set the process in motion. Inform the student that she has free range and that what she journals is up to her.

These prompts can/should be adjusted according to the specific need or area where a positive appraisal is required, for example: if the student feels and/or sees herself as somebody with no worth, the SP can suggest prompts that could address it, such as: "I am proud of the following three things that I accomplished today". The student should be encouraged to discuss prompts and aspects that she might be struggling with, with the SP in order to address any challenges in a timely and appropriate manner.

Table 6.6: Example of a Self-Esteem Journal

Prompt (suggested by the SP)	Date	Student's response
<i>My loved ones are proud of me because...</i>		
<i>My best quality is:</i>		
<i>I feel best about myself when...</i>		
<i>My greatest accomplishment today was:</i>		
<i>Three things that brought me peace today:</i>		
<i>Two things that make me unique are:</i>		

d) Practice guidelines for challenging negative self-talk

Negative self-talk has been found to be quite prominent where an individual presents with a negative self-esteem and/or unrealistic self-concept. This behaviour furthermore has been linked to higher levels of stress and it was found that it could lead to decreased motivation, feelings of helplessness, and even depression (Barton et al., 2017; Moore et al., 2017:108; Grey, 2014:1201; Maçola, Do Vale & Carmona, 2010:570). Engaging in negative self-talk has been found to be prevalent amongst women experiencing an UP (Moore et al., 2017:108; Maçola et al., 2010:570). It was also found to be prevalent amongst the research participants of this study (see Section 4.3.1.3).

The practice guidelines given below are suggested in order to challenge and change such negative self-talk.

The SP should encourage the student to do the following:

- Be on the lookout for and identify her negative or self-criticising thoughts. She should become aware of how often she thinks negatively about herself, what prompts such thoughts, and in what way it makes her feel negative about herself. She needs to evaluate if such thoughts are real and a “truth”, and whether it is only applicable given the current crisis circumstances. She needs to be assisted on how to manage such thoughts by way of thought stopping or replacing negative (unrealistic) thoughts with positive ones.
- Speak positively to herself, engaging and practicing positive and affirming self-talk.
- Convert all "shoulds" into "coulds", for example, if she feels that she should do

something that is not particularly important to her, or is based on what other people think she should do, she could challenge herself to do only those activities that will reinforce her positive self-concept and strengthen her self-esteem.

- Start exercising, as physical exercise is an excellent way to strengthen her self-concept. Physical exercise, in addition to improving one's body and health, nurtures positive thoughts and feelings because bio-chemicals released by the brain during exercise create a natural and healthy "high" (Knapen, Vancampfort, Moriën & Marchal, 2015:1491).
- Learn from her mistakes without self-punishment by reframing the concept "mistake" as follows: *"There are no mistakes, only lessons."* Emphasise that human beings learn through experience.
- Learn from past errors and then let them go. She should practice self-forgiveness and learn self-acceptance.

6.3.5.5 Practice guidelines for assessing and addressing the presence of depression and stress experienced as a consequence of the UP-experience and during the decision-making process in view of the management thereof

For a TS the event of an UP denotes a loss (Peila-Schuster, 2016:56), not only because she might be losing the opportunity to be a "carefree student", but also because of the fact that she may have to discontinue her studies as a result of the occurrence of her UP. Her UP might furthermore lead to her losing her standing in the community or amongst her peers/significant others). In the long run, especially where she opts to manage the UP by having a TOP or giving the child up for adoption, permanent losses are experienced (Grey, 2015:737; Rochat et al., 2015:125). The multiple losses may result in the experience of stress, sadness, and depression (Harries et al., 2015:6; Bradshaw & Slade, 2013:934).

a) Practice guidelines and tools for assessing the presence of depression

In focusing of the aspect of depression in the provision of psychosocial support, the SP should ascertain if the student has a history of depression, or if the symptoms of

depression are situation-related (Alpaslan, 2018:317) and a response to the stress and loss experienced as result of the UP and/or TOP.

Where the aspect of depression surfaced during the biopsychosocial assessment conducted in the initial phases of the helping process, the presence of depression should be assessed more pertinently. This exploration and assessment can be done by directing the following questions, adopted and adapted from the ***Patient Health Questionnaire for Depression (PHQ-9)*** (Kroenke, Spitzer & Williams, 2001) to the student:

- Are you feeling irritable, down, hopeless, or depressed?
- Do you find that you have little or no interest in doing things that you enjoyed previously?
- Do you find that you don't have energy to do the things that you enjoyed previously?
- Are you having trouble falling asleep or staying asleep, or do you sleep too much?
- Do you feel tired most of the time?
- Do you have a poor appetite or are you overeating?
- Do you feel that you have let yourself or your family down?
- Do you feel that you are a disappointment to yourself or your family?
- Do you have trouble concentrating or focusing on your studies?
- Has your behaviour changed, for example from being active to being passive?
- Do you find that you isolate yourself from others?
- Have you had suicidal thoughts or have you attempted suicide in the past?
- Are you currently experiencing suicidal thoughts?

Note to the SP: Any "yes" answer could point to the presence of depression and should be further explored, for example: How often do you experience a particular symptom such as trouble with sleeping... loss of appetite... feeling tired... feeling irritable, down, hopeless or depressed... or struggling to concentrate? What would you say lies at the root of all of this? Was there another time in your life when you experienced this symptom? If so, when and how long did it last? What, in your opinion, was/is the cause thereof, how did/does it affect your functioning, and what did you do/are you doing to cope with it?

b) Practice guidelines for the management of depression

There are a variety of methods to deal with depression and often they are best used in conjunction with each other. The primary medical options are Cognitive Behavioural Therapy (CBT), antidepressant medication, and in some severe cases, Electroconvulsive Therapy (ECT) (Kline, Cooper, Rytwinski & Feeny, 2018:31). The SP should not be hesitant to refer the student for medical help to treat the depression experienced by her and a proactive rather than a reactive approach is suggested.

In the context of the SP's provision of psychosocial support, providing information and coping strategies to assist the student in managing her depression is suggested. Greater control in turn may lead to reduced feelings of helplessness and an increased sense of wellbeing. Providing education for families or carers is also very important to help increase the support and assistance they provide to the student.

The SP could suggest the following behavioural strategies to address the symptoms of depression:

- The student should set goals for daily activity. It is recommended that she plans full days of useful activity by making a list of the activities that she is going to engage in at different times during the day. She should try to stick to her plan as closely as possible.
- She could make a list of the activities that she enjoys and she should try to increase the amount of time spent on these enjoyable activities.
- She should avoid comparing the way she is behaving or feeling while experiencing depressive symptoms to the way that she used to behave or feel before becoming depressed.
- She should ask for and enlist the support and encouragement of her friends and significant others in assisting her with coping with the depression.

- c) Practice guidelines and tools for assessing the presence of stress resulting from the UP

It is averred that feelings of worry and stress resulting from the experience of an UP are common and normal (Barton et al., 2017; Nelson & O'Brien, 2012:507; Kjelsvik & Gjengedal, 2011:169). The TS confronted with this crisis tends to experience stress with regard to her future, her studies, finances, and relationships, as well as the decision that she has to make in terms of how she will manage her UP (Hall et al., 2017:1337; Adams & Williams, 2011:1881).

In order to identify and assess the presence of stress in the life of the TS presenting with an UP, utilisation of the ***Perceived Stress Scale (PSS)*** (Cohen & Williamson, 1988), adopted and adapted as practice guideline, is suggested. This assessment tool, developed in 1983, assists in understanding how different situations impact on the feelings and perceived stress level of an individual, in this case the TS. Worth noting is the fact that while two individuals could experience the same crisis situation, how they perceive it and their feelings and emotional reactions resulting from it, will cause them to score differently on the PSS.

Utilisation of this tool involves an exploration of the student's feelings and thoughts, as experienced since the confirmation of her UP, by the SP requesting that that she indicates how often she felt or thought in a specific way. The student is provided with the PSS and requested to answer each of the questions by indicating her response on a five-point scale: 'very often' carries a score of 4, 'fairly often' carries a score of 3, 'sometimes' carries a score of 2, 'almost never' carries a score of 1, and 'never' has a 0-value.

+Scoring: Note to the SP: Statements 4, 5, 7 & 8 in the PSS are positively phrased and the scores provided by the student need to be reversed. For example: 0 becomes 4; 1 becomes 3; 2 remains 2; 3 becomes 1; and 4 becomes 0. Add all numbers to all the statements after reversing the scores as per statements 4, 5, 7 & 8.

Interpretation:

Individual scores on the PSS can range from 0 to 40 with higher scores indicating higher perceived stress.

- A score between 0 and 13 indicates low stress
- A score between 14 and 26 indicates moderate stress
- A score between 27 and 40 indicates high perceived stress

Table 6.7: The PSS (adopted and adapted for the guidelines)

Question: Since the confirmation of your UP...		Tick the appropriate response				
		Never (0)	Almost never (1)	Some- times (2)	Fairly often (3)	Very often (4)
1	...how often have you been upset by it?					
2	...how often have you felt that you do not have the ability to control the important things in your life?					
3	...how often have you experienced feelings of tenseness, uneasiness, and stress?					
4	...how often have you felt sure that you are able to deal with your challenges?					
5	...how often have you felt that everything in your life is working according to plan?					
6	...how often have you found that you could not cope with all the things that you had to do?					
7	...how often have you been able to deal with irritations in your life?					
8	...how often have you felt that you were in control of everything in your life?					
9	...how often have you experienced feelings of anger as a result of it?					
10	...how often have you felt overwhelmed by it?					
Total score						

- d) Practice guidelines for the management of the stress experienced as a result of the UP

Where the student scored high on the adapted PSS, the SP should further explore the particulars around this matter by posing the following questions to focus such exploration: I would like you to take a moment and tell me about your stress and worries that were brought about by your UP-experience? What are the challenges brought about by this experience?

In view of assisting the student to manage the stress experience, the following suggestions are forwarded:

- Instruct the student to make a list of all the aspects stressing her and then engage with her in terms of which of these she can address and which of these she should embrace/accept. It is suggested that the SP and student, in terms of the stressors that the student can do something about, brainstorm about alternatives for this purpose.
- Relaxation and deep breathing exercises could be recommended as a way to ease the tension experienced.
- In assisting the student to “cope” better with the stress experienced, she can be advised to –
 - adopt and maintain a positive attitude;
 - accept that there are events that she cannot control;
 - exercise regularly;
 - eat healthy, well-balanced meals; and
 - manage her time more effectively.

Apart from the suggestions mentioned, the SP can demonstrate and facilitate a creative visualisation exercise to assist the student to “let go” of her stress. This entails giving the student a balloon and asking her to draw symbols, representing her stress, on the balloon. She should then “blow her stress into the balloon”, after which she can either pop her balloon with a drawing pin or she can go outside and let go of her balloon (symbolising the release of her stress).

Exploring and assessing depression and stress experienced by the student in the context of an UP and in the midst of deciding on how to manage this crisis situation, as well as the interventions that can be used to manage the stress and depression, tie in with the facets of **Support** (referring to professional and non-professional sources of support available to assist the student in this regard) and **Strategies** (referring to the ways in which the student can be assisted to cope with these challenges) in Schlossberg's Transition Model (Schlossberg, 2011:160-161).

6.3.5.6 Practice guidelines for appraising and enhancing the resources and assistance available to assist during the UP and the decision-making process to deal with the UP

The type of resources and assistance available to assist the TS presenting with an UP with specific reference to the decision-making process on how to deal with the UP are central in her transition to adaptation. Providing the student with an opportunity to appraise the resources and the assistance available (or the lack thereof) during the time of her UP and whilst having to decide on how she is going to manage this crisis ties in with the facet of **Support** in Schlossberg's Transition Process Model (Schlossberg, 2011:160). The availability or lack of institutional sources of support, such as the counselling and health and wellness service departments on university campuses, social welfare organisations, religious institutions and community service organisations, as well as the availability (or lack) of an interpersonal convoy of support with reference to the student's significant others (her family, friends, or partner), all plays an influential role in her coping with the decision-making process in managing the UP and her ultimate adaptation to the transition.

Aside from the formal and/or informal support available, the student's immediate physical setting, inclusive of aspects such as her neighbourhood and living arrangements, likewise will influence the option she chooses to manage the UP and her adaptation to transition.

Informed by the TS-participants' accounts pointing to both the utilisation of on-campus and off-campus institutional sources of support, the interpersonal sources of

support accessed and utilised, their positive appraisal thereof, and their suggestions for more information on the available sources of support and assistance in terms of how to ascertain more interpersonal support from significant others (see Section 4.3.3.1 – 4.3.3.3), SPs are to be made aware of the critical role of support in assisting the student in her decision-making process on how to deal with the UP and her process of adaptation to transition.

In view of this, the following practice guidelines are suggested:

- a) Practice guidelines for exploring the interpersonal and institutional sources of support available that could help/hinder the student in the UP-crisis and the decision-making process on how to manage it

In order to explore the ***interpersonal convoy of support*** available to the student presenting with an UP, the SP should invite her to reflect on her perception of whom she can turn to for support with the UP-crisis and the decision-making process regarding the management thereof. Obstacles in terms of people and processes that could hinder or refrain from supporting her should also be identified. The following questions are suggested in this regard:

- “Who, in terms of the people close to you or in your personal network, or even your neighbourhood, could you approach or turn to, who would be willing to provide you with practical assistance, advise, or emotional, financial, spiritual and/or academic support in your UP-crisis and in your decision-making process on how to manage the UP that occurred?” Encourage the student to elaborate and be specific on how the individual identified could be a source of support.
- “Who, in terms of the people close to you or in your personal network, or even your neighbourhood, would you rather not approach or turn to and would not be willing to provide you with practical assistance, advise, or emotional, financial, spiritual, and/or academic support in your UP-crisis and in your decision-making process on how to manage the UP that occurred? How did you arrive at the conclusion about this perceived (or actual) unwillingness to provide support or what do you perceive as the reasons for their perceived and/or actual unwillingness to support you?”

- “What about reaching out for interpersonal support scares you? What are your reasons for being scared?”
- “How will the interpersonal support or the lack thereof help or hinder you in your decision-making process on how to deal with the UP?”
- “What makes it easy to reach out for support (with the UP and the decisions you have to take about managing it) to your significant others in your interpersonal network of family, friends, and/or neighbours?”
- “What makes it difficult to reach out for support (with the UP and the decisions you have to take about managing it) to your significant others in your interpersonal network of family, friends, and/or neighbours?” Possible hindrances in this regard can include feelings of guilt, shame, fear of rejection, fear of losing relationships, and fear of stigmatisation, as alluded to by the participants of this research study (see Section 4.3.3.2 – 4.3.3.3) and confirmed by literature (Calvert et al., 2013; Upadhyia & Ellen, 2011:538). It is therefore suggested that the SP explores this aspect.
- “What needs to change in you and in them that will enable you to utilise the wealth of interpersonal support available to you during your UP-crisis? What are you prepared to do or planning do to?”

In addition to the questions above, a ***relationship diagram*** (adopted and adapted from Alpaslan, 2018:319-320) is suggested as assessment tool for assessing the interpersonal support available to the TS.

For this exercise, in session, provide the student with a clean sheet of paper and coloured pencils. Ask the student to position herself as a circle in the middle of the sheet. Ask her to identify the people that she perceives to be her significant others (such as family members, friends, her partner) and position them around her on the sheet. A pencil of a different colour can be used for each person. Where she perceives or enjoys a close relationship with them, she can position them closer to her and indicate the relationship between her and them with a straight line. Where a conflictual or a distant relationship (actual or perceived) exists between her and a significant other, she can indicate it by way of a dotted line and position them further from herself. Upon completion of this exercise, invite the student to present the relationship diagram. Enquire about the close relationships, what makes them close,

and how they can be of support to her. Concerning the distant relationship(s), enquire about the reason(s) for this and what can be done to change the current state of affairs, especially in view of enlisting this support in the transition set in motion by the UP.

The following questions could be directed at the student in an attempt to appraise her perception of the ***institutional sources of support*** to her avail:

- “Are you aware of any resources (organisations, groups, people) in your community, at your tertiary institution, or at your place of residence that you can turn to for practical assistance, advise, counselling, or medical, financial, spiritual, and/or academic support?” (The student should be asked to be specific in this regard and to identify and elaborate on who/what is available as well as her reason for identifying a specific person or resource).
 - “What about reaching out for institutional support scares you... what are your reasons for being scared?”
 - “How will the institutional support or the lack thereof help or hinder you in your decision-making process on how to deal with the UP?”
 - “What makes it easy to reach out for institutional support with the UP and the decisions you have to take about managing it?”
 - “What makes it difficult to reach out for institutional support with the UP and the decisions you have to take about managing it?” Possible hindrances in this regard can include lack of information about available resources, difficulty in accessing or non-utilisation of resources, lack of information regarding the UP-options, and negative, judgemental attitudes from SPs, as alluded to by the participants of this research study (see Section 4.3.3.2 – 4.3.3.3 and Section 5.3.4.2) and confirmed by literature (Grey, 2015:737; Van Breda, 2011:24). It is therefore suggested that the SP explores this aspect.
- b) Practice guidelines for accessing the interpersonal and institutional sources of support available to assist the student during the UP-crisis and the decision-making process on how to manage it

In order to elicit the support of the student’s significant others, which is critical in terms of the decision-making process, the SP can offer/suggest that she, on behalf of

and with the permission of the student, reach out/contact the significant others to inform them of the crisis. The SP can then invite the significant others to a family conference/counselling session (between the SP, student, and the parents, caregivers, or any other extended family members identified by the student as significant in her life), couples counselling session (between the student, her partner, and the SP), or a joint counselling session (between the student, any other significant other, such as a close friend, and the SP).

Where emotions such as shame or fear prevent the student from accessing support (in other words reaching out/approaching her significant others for support), the SP can suggest the utilisation of role-playing. This is useful in preparing the student for a challenging situation or difficult conversation, as it allows for an exploration of how her significant others are likely to respond. The SP assists by improvising/acting out the anticipated behaviour of the significant other and in so doing the student is provided with an opportunity to practise how to inform her significant other of her UP, to express herself, and ask for assistance and support. The student should be encouraged to be specific with regard to expressing herself, her emotions, and her support needs.

Letter writing can also be utilised to elicit and access support. This tool is useful when an in-person meeting/conversation with the significant others is not possible, for example due to physical distance or where emotions such as shame or fear prevent the student from approaching her significant others. While in session, the student is requested to write a letter to the person(s) that she wishes to inform of her UP and approach for support. She should be encouraged to openly and honestly express herself, her emotions, and her support needs. Upon completion, the student should read the letter to the SP, who can offer guidance and feedback. If needed, changes to the content of the letter can be made, after which the student can decide if she wants to send her letter to her significant other(s) (she might, after expressing herself in this way, feel that she was provided with an opportunity to “vent” or prepare herself sufficiently and she might, as a result thereof, prefer to either verbalise the content of her letter in a meeting/conversation with her significant other or read it to them herself). Should she decide to send the letter to her significant other, the SP

should arrange for a follow-up session to discuss the outcome of this process and provide further guidance and assistance.

Mobilising the support of and encouraging the involvement of the significant others is beneficial, as it assists with protecting the student against the stress experienced as a result of her transition; it provides reassurance, comfort, safety, and support and commitment from significant others to assist with the TS's adaptation to the transition (Feeny & Collins, 2015:114-115; Workman, 2015:5; Berge, MacLehose, Eisenberg, Laska & Neumark-Sztainer, 2012:6-7).

Taking into account the suggestions from the participants of this study (see Section 4.3.4.1, 5.3.5.1 & 5.3.5.2) and the literature on institutional support (Baird & Porter, 2011:10; Kjelsvik & Gjengedal, 2011:172; Van Breda, 2011:6, 8, 26), in order to be available to students presenting with an UP, SPs need to be up to date with the institutional sources of support available to the student.

In terms of accessing academic support, the SP can, if the student expresses such a need, liaise with or facilitate a meeting/consultation with the student's academic department or a lecturer in order to elicit the appropriate academic assistance.

A booklet with institutional resources is suggested. This booklet should contain contact details that the student can reach out to/approach for practical, medical, emotional, financial/material, and/or spiritual support. In addition, updated, correct and user-friendly information on the different UP-options and service organisations rendering specialised services in terms of foster care, adoption, and TOPs should be provided to the student, together with information on healthy sexuality, contraception, and the TOP-procedure. Increased and improved communication, networking, and cooperation in view of referral to institutional support systems are strongly encouraged.

6.3.6 Practice guidelines for reflecting on the decision taken to manage the UP and the outcome thereof

How the TS decides on an option or a way to manage the UP ties in with the facet of **Strategies** in Schlossberg's Transition Process Model (Schlossberg, 2011:160).

The aim of the provision of psychosocial support to the TS presenting with an UP is to ensure that the manner in which she decides to manage her UP would in the end assist her to reframe this crisis experience as an opportunity for growth (Alpaslan, 2018:308; Schlossberg, 1981:7), to reduce stress and establish a new sense of self-esteem and hope (Grey, 2014:1201, Sereno et al., 2013:145; Schlossberg, 1981:8).

6.3.6.1 Strategies for exploring, assessing, and intervening in the variables influencing the decision-making process related to the management of the UP and reflecting on the outcome thereof

As the experience of an UP signifies a crisis in the life of the TS, that in many instances are managed in a hasty fashion that is later regretted, how the student decides to manage the UP (in terms of either parenting the child, foster care, adoption, or a TOP) and the variables informing such a decision need to be explored and assessed. The accounts from the TS-participants (see Section 4.3.2.1 – 4.3.2.3) in this research study and the literature consulted (Grey, 2015:738; Tabane & Mmapheko, 2015:6-7; Daley, 2012:39), point to the fact that how the student intends to manage her UP is strongly influenced by support or the lack thereof from significant others, spiritual/religious and cultural considerations, counselling and medical support available, as well as financial and academic pressures. The feelings and emotional reactions following the decision taken with regard to the UP have furthermore been found to vary from relief, happiness, and contentment, to the experience of severe distress and trauma (Frederico et al., 2018:335; Hall et al., 2017:1338; Kjelsvik & Gjengedal, 2011:173; Steck, 2011:18).

Part of the agenda of psychosocial support to a student presenting with an UP is to find out about how she plans to manage the UP or what decision was taken and what

informed her decision. The following questions could be used to explore these aspects:

- “Please share with me how you plan to deal with the UP (what decision are you planning to take/did you take in order to deal with your UP)?”
- “What and/or who informed this decision?”

Before this decision is executed, the SP should provide the student with comprehensive information about the options available to manage the UP. It is suggested that the pros and cons of each option is deliberated in view of assisting the student to make an informed decision on how to manage her UP. The options available to manage the UP were presented and elaborated upon earlier in this chapter (see Section 6.3.3) and in Chapter One (see Section 1.1.1.5), and is now further deliberated by offering suggestions to explore and manage the outcome of the UP, namely to assist the student with a review of/reflection on her decision taken to manage her UP. This entails exploring how she feels about the decision and how she is coping with it; determining whether the strategies applied by the student to cope with her decision are sufficient, helpful, and adding to healthy adjustment; and offering recommendations for additional coping strategies.

a) Parenting/single parenting

The experience of higher levels of stress, loneliness, isolation, anxiety, or depression has been found to be prevalent amongst single parents, more so if the single parent is also an unmarried TS (Stack & Meredith, 2018:233; Grey, 2015:737).

The following questions will assist the SP in her exploration of how the student is feeling about and coping with choosing parenting as option to manage her UP:

- “How do you feel about your decision to choose parenting as option to manage your UP?”
- “How did you prepare/were you prepared/are you preparing for parenting?” (This entails an exploration of arrangements/plans made by the student with regard to medical care and support such as prenatal care and contraception to prevent another UP; her studies, namely determining whether is she able to continue with her studies or whether she will take a leave of absence, and

whether she familiarised herself with the policies, rules and regulations of her tertiary institution regarding student pregnancy and residence accommodation during and after student pregnancy; her finances, regarding how she will manage the additional expenses brought about by the birth of her baby; relationships, particularly whether the father of her child is going to be involved in her and her child's life and what the role of her significant others will be; and what arrangements are in place in terms of aspects such as accommodation and childcare).

- "How are you coping with your decision to parent?"
- "Please share with me the types of support that you received/are receiving" (this entails an exploration of the "who", "what", and "how" of the support).
- "Please share with me your experience of this support (or the lack thereof)?"
- "How would you describe the support that you received/are receiving?" (In other words, is it sufficient? If not, why not and what would you have liked to be different about it?)

In order to address challenges expressed and experienced by the student who chose parenting and to support and enhance the strategies employed by her, the SP could recommend the following:

- Obtaining financial assistance: if the student is registered for full-time studies, she may apply for financial support from the government in the form of the CSG. The student could also be encouraged to apply for a bursary/study loan.
- Strengthening her relationships with her significant others and obtaining their support and assistance: this could refer to and include financial support, emotional support, and practical support such as assisting with childcare when she is attending class.
- Obtaining academic support: this could refer to making arrangements for a temporary leave of absence during the birth of her baby or arrangements to write a test/exam at a later stage, if needed. If the student struggles with academic related matters such as time management, guidance and assistance could be provided or an appropriate referral for study counselling should be made.
- Joining a single parent support group: the aim of support groups for single parents is generally to provide a platform for sharing concerns and challenges

associated with single parenting, such as financial pressures, parenting skills, or loneliness. It might also provide the student with an opportunity to establish meaningful friendships with other single parents.

- Getting counselling: whether it be individual or group counselling, it can provide the student with guidance and support regarding the responsibilities and challenges associated with single parenting and also assist with the identification and establishment of a reliable support system.

b) Foster care

Foster care refers to the temporary placement of a child who is in need of care and protection. The child is placed in the care and custody of a suitable family or person who is not the parent or guardian of the child and the child is maintained by means of a foster child grant. This statutory process is facilitated by a social worker from the Department of Social Development (DSD) or designated Child Protection Organisation, through the Children's Court (DSD, 2018).

If the student's UP is managed/dealt with by means of this option, the SP should explore what and/or who informed this decision. The following questions will furthermore assist the SP in her exploration of how the student is feeling about and coping with the decision taken to place the baby in foster care:

- "How do you feel about the decision taken to place your child in foster care?"
- "How did you prepare/were you prepared/are you preparing for this decision?"
(This entails an exploration of the student's liaison and interaction with the relevant social welfare organisation/social worker in private practice to facilitate the foster care process; her arrangements/plans with regard to medical care and support in terms of the birth of her baby, medical check-ups, and contraception to prevent another UP; her studies, concerning leave of absence during the birth of the baby; and whether she familiarised herself with the policies, rules, and regulations of her tertiary institution regarding student pregnancy and residence accommodation, if applicable, during her pregnancy).
- "How are you coping with your child being placed in foster care?"

- “Please share with me the types of support that you received/are receiving” (this entails an exploration of the “who”, “what”, and “how” of the support).
- “Please share with me your experience of this support (or the lack thereof)”.
- “How would you describe the support that you received/are receiving” (is it sufficient and if not, why not, and what would you have liked to be different about it)?

In order to address challenges expressed and experienced by the student whose UP is managed by means of foster care and to support and enhance the strategies employed by her in this regard, guidance and support from the SP could include the following:

- Assisting with/ensuring that an appropriate referral to a social worker/child and family welfare service organisation, sanctioned to facilitate the foster care process and procedure, is made.
- Encouraging the student to actively participate in any support and/or reconstruction services offered by the mentioned social worker/child and family welfare service organisation with the purpose of reunifying the student with her child.
- Encouraging the student to enlist the emotional support of her significant others.
- The provision of or referral for counselling and/or academic support, and/or referral to a support group for mothers with children in foster care.

c) Adoption

Although adoption is a choice, it is not an easy decision. Life-changing decisions are never easy and this decision usually results in the experience of intense emotions, such as sadness, guilt, doubt, and resentment (Rochat et al., 2016:125; Walkner & Rueter, 2014:880) which, if not managed constructively, have the potential to derail the life of the student (Rochat et al., 2016:124).

Aside from exploring what and/or who informed the adoption decision, utilisation of the following questions is recommended to assist the SP in her exploration of how the student is feeling about and coping with this decision:

- “How do you feel about choosing adoption to manage your UP?”

- “How did you prepare/were you prepared/are you preparing for this decision?” (This entails an exploration of the student’s liaison and interaction with the relevant social welfare organisation/social worker in private practice to facilitate the adoption process; her arrangements/plans with regard to medical care and support in terms of the birth of her baby, medical check-ups, and contraception to prevent another UP; her studies, concerning leave of absence during the birth of the baby; and whether she familiarised herself with the policies, rules, and regulations of her tertiary institution regarding student pregnancy and residence accommodation, if applicable, during her pregnancy).
- “How are you coping with your adoption decision?”
- “Please share with me the types of support that you received/are receiving” (this entails an exploration of the “who”, “what”, and “how” of the support).
- “Please share with me your experience of this support” (or the lack thereof).
- “How would you describe the support that you received/are receiving” (is it sufficient and if not, why not, and what would you have liked to be different about it)?

In order to address challenges expressed and experienced by the student who chose adoption to manage her UP and to support and enhance the strategies employed by her, the SP should ensure that the student is referred to an appropriate private social service organisation, government agency, or child and family welfare organisation, sanctioned to facilitate the adoption-process. Counselling, with the aim of assisting the student to acknowledge and address the following, should also be recommended:

- Giving up a child for adoption is an emotionally complicated decision. The healing process requires dealing with self-doubt, grief, and loss (Rochat et al., 2016:125; Walkner & Rueter, 2014:880; Benokraitis, 2005:305-306).
- Accepting the adoption decision to manage the UP is the first step in dealing with the grief, loss, and other associated intense emotions.
- Feeling overwhelmed by emotion after the adoption is normal, but also very upsetting. The student might experience symptoms of stress, anxiety, depression, or trauma, as well as several behavioural disturbances, such as headaches or trouble sleeping or eating, as a result of these symptoms. The aim of the counselling process in this regard is to appropriately and effectively address this (Rochat et al., 2016:125; Walkner & Rueter, 2014:880).

- Upon acceptance of the adoption and having constructively dealt with the emotions and reactions, the student might start dreaming or fantasising about the child's life (such as what the child might look like or feelings of sadness on the child's birthday) (Rochat et al., 2016:125; Walkner & Rueter, 2014:880). The SP should assure the student that these dreams and fantasies are a normal part of the healing process and assists with acceptance of the adoption decision.

d) Termination of the UP

The termination of a pregnancy, elaborated upon extensively in this thesis (see Section 1.1.2, 1.5.11, and 6.2.3), refers to the deliberate induced termination of a pregnancy (Stoyles, 2015:97; Moscrop, 2013:99). There are two types of induced TOP, namely medical or surgical TOPs, with the latter referring to a surgical procedure to remove the contents of the uterus (Ireland et al., 2015:23) and the former being a non-surgical procedure (by means of pharmaceutical drugs) (Ireland et al., 2015:23). A TOP is generally performed by a medical practitioner in an approved health facility or designated TOP clinic (Blanchard et al., 2015:331; Harries et al., 2015:1).

Aside from exploring who and/or what informed the student's decision to manage her UP by means of a TOP, it is suggested that the SP direct the following questions to the student in order to assess how she is feeling about and coping with her TOP decision:

- "How do you feel about your decision to terminate your UP?"
- "How did you prepare/were you prepared/are you preparing for the TOP?" (This entails an exploration of arrangements/plans made for the TOP, such as whether she made the appointment for the TOP herself or was it made by someone else on her behalf, and if so, by who? Where was/will the procedure be conducted – was/is it at an approved healthcare facility? Was/Is she adequately prepared for and informed about what the TOP-procedure entails? Have arrangements been made with regard to medical care and support after the TOP-procedure, and contraception to prevent another UP? Have arrangements been made regarding her studies – will she take a leave of

absence during/after the procedure? How/By whom will the TOP-procedure be funded?)

- “How are you coping with your decision to terminate your UP?”
- “Please share with me the types of support that you received/are receiving” (this entails an exploration of the “who”, “what”, and “how” of the support).
- “Please share with me your experience of this support” (or the lack thereof).
- “How would you describe the support that you received/are receiving” (is it sufficient? If not, why not, and what would you have liked to be different about it?)

In order to address challenges expressed and experienced by the student choosing TOP to manage her UP, to support and enhance the strategies employed by her and taking cognisance of the fact that the experience of PAS/trauma as a result of the termination of an UP has been established (Curley & Johnston, 2013:279), SPs should ensure that they are familiar with this phenomenon, able to provide appropriate support, and/or able to refer the student if needed.

As PAS is acknowledged as a type of PTSD, characterised by the chronic or delayed development of symptoms resulting from affected emotional reactions to the physical and emotional trauma of a TOP (Rocca et al., 2015; Curley & Johnston, 2013:279), the SP should have knowledge of psychological interventions specifically addressing this phenomena. The value and importance of such interventions is reiterated by literature (Curley & Johnston, 2013:281; Mota, Burnett & Sareen, 2010:239) and was emphasised and appraised by the TS and SP research participants of this study (see Section 4.3.3.3, Category 3.3.4; Section 4.3.4.1, Category 4.1.1 & 4.1.2; Section 5.3.2.1, Category 2.1.6; and Section 5.3.5.1).

SPs have an ethical and professional obligation to provide assistance and support that address the psychological aftermath of a TOP (Curley & Johnston, 2013:290). This sentiment is also resonated in the CTOP 92 of 1996 (South Africa, 1996) and the CTOP Amendment Act 38 of 2004⁵⁰ (South Africa, 2005), which, aside from prescribing the circumstances under which the pregnancy of a woman may be

⁵⁰ Presented and elaborated upon earlier in this thesis. See Section 1.1.2.1 and 6.2.3).

terminated, also emphasise the importance of the provision of non-compulsory counselling before, during, and after a TOP. It is recommended that SPs ensure that students considering TOP as an option to manage their UPs are informed of the recommendations and provisions of the mentioned Acts.

Where the student has undergone a TOP, the following ***strategies for intervention in the PAS experienced by the student, as practice guidelines, are suggested:***

6.3.6.2 *Eagle's Integrative Model for Brief Term Intervention in the Treatment of Psychological Trauma (adopted and adapted from Eagle, 1998)*

Informed by the section above, ***Eagle's Integrative Model for Brief Term Intervention in the Treatment of Psychological Trauma*** (also known as and referred to as the Wits Trauma Counselling Model) (Eagle, 1998) is suggested for the PAS that may manifest following a TOP. It consists of five components that can be introduced interchangeably, depending on the needs of the client and the natural course of the counselling session:

- *Component One* refers to ***telling/re-telling the story***, which entails a detailed recall of the TOP, in sequence, and includes the facts, feelings, cognitions, and sensations experienced by the student. The utilisation of techniques such as present tense narration, application of the metaphor of watching a film in slow motion, or encouraging sensory associations is recommended to enhance the detailed recall.
 - o This act of remembering may facilitate the expression of suppressed emotions associated with the TOP and it provides an opportunity to symbolise the TOP-experience verbally. The story telling furthermore enables for the creation of some cognitive structure around her TOP, thus facilitating the processes of assimilation and accommodation into existing cognitive frameworks.
- *Component Two* refers to ***normalising the symptoms***, which involves solicitation and anticipation of the experienced symptoms. It entails a discussion of the PAS symptoms, as well as the provision of information and education

about post-traumatic symptoms. Links between the TOP and symptoms experienced are made and reassurance is given about the normality and the time-limited nature of the mentioned symptoms (Eagle, 1998:140). The anxiety reduction associated with the latter prevents the development of negative thoughts. This, combined with an element of reassurance that symptoms will diminish with time, gives this component a strong psycho-educational focus. There is also a strong focus on empathy and understanding in this component, which has been found to lead to an improved understanding of and reduction in the trauma-related symptoms (Eagle, 1998:140).

- *Component Three* refers to **addressing self-blame or survivor guilt (restoring self-respect)**. Self-blame is seen as detrimental to self-esteem (Eagle, 1998:141) and thus the goal of attainment of self-respect is paramount in terms of this intervention. Suggested techniques include guided imagery (which may enable the internalisation of the TOP with less shame or denial), encouraging her to take a third person distanced position in relation to considering her actions; reducing judgements inflicted by significant others; strengthening the fact that her actions enabled her to, for example, continue with her studies and pursue her academic goals; and emphasising that asserting her judgement in the situation was the only valid vantage point from which to respond. The reinforcement of any behaviour, thoughts, and strategies deemed as effective in the situation is also encouraged, as this could be indicative of some mastery in the situation (Eagle, 1998:141). This step/component is seen as a cognitive reframing endeavour and it is postulated that reducing the irrational thoughts could result in bringing doubts about efficacy and blame into conscious awareness with the purpose of assisting the student to reconcile herself with the reality of the occurrence of the TOP, as well as her role in the event, without damage to her self-concept (Eagle, 1998:142).
- *Component Four* refers to **encouraging mastering**, which aims to restore the client to her previous levels of functioning and to counteract the feelings associated with the TOP. Anxiety management techniques, such as progressive relaxation, thought stopping, behavioural rehearsal, and time structuring (addressing concentration and avoidance problems), form an integral part of

this intervention. Additional techniques, such as semi-structured, self-undertaken, systematic desensitisation, are also encouraged in relation to avoided stimuli (Eagle, 1998:142). In keeping with behavioural skills training principles, it is emphasised that goals should be attainable and manageable so that the student experiences success in mastering the impact of the trauma. The utilisation of the mentioned behavioural techniques can be seen and understood as ego-supportive and inclusive of encouragement of more adaptive defences. Eagle (1998:143) states that such mastery reduces regression and promotes the student's experience of self-efficacy to be internalised again. As improvement is experienced, attempts at mastery become self-reinforcing, which creates an attitude of greater optimism. The latter has been found to facilitate the creation of meaning, which is the final component in the model.

- *Component Five* refers to ***facilitating the creation of meaning***. The capacity to derive meaning from a traumatic event is often seen as a long-term process – it is therefore seen as optional and should not be imposed on the client (Merrill, Waters & Fivush, 2016:1322; Schnyder, Ehlers, Elbert, Foa, Gersons, Resick, Shapiro & Cloitre, 2015; Eagle, 1998:143). It has been found, however, in some cases of brief term therapy, that the client will spontaneously introduce the issue of meaning (Merrill et al., 2016:1322; Schnyder et al., 2016). The role of the therapist then is to facilitate this by means of, amongst others, engaging with the client's belief system on a cultural, political, spiritual, or existential level. The purpose of such is to be respectful of the client's existing beliefs in attempting to assist her to derive meaning from her experience, but also to create hope and future perspective without denying the damage done (Eagle, 1998:143). This component can be understood as improving the client's ability to internalise or understand herself to be a survivor rather than a victim of her TOP-experience, and to live with a view of herself and the world in a way which may enhance her future orientation (Eagle, 1998:143).

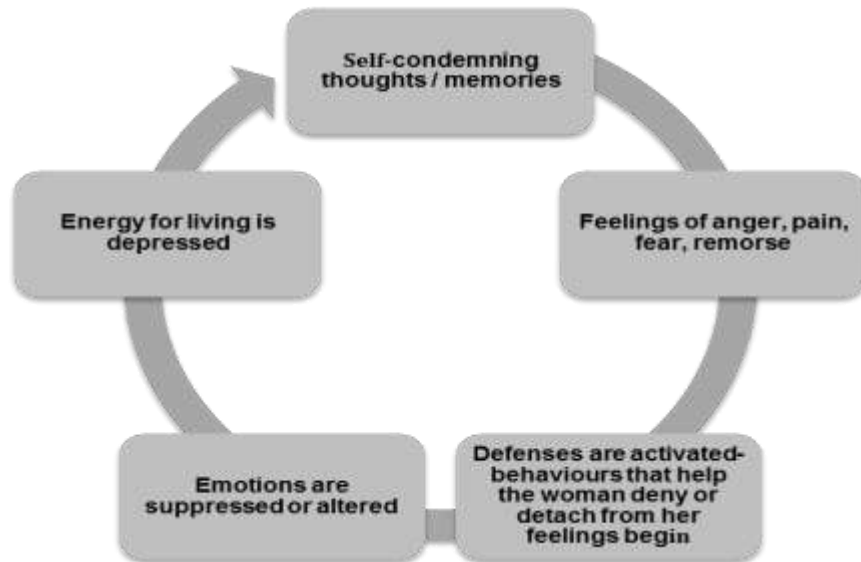
6.3.6.3 *“The Journey: a road to post-abortion recovery” (adopted and adapted from Thompson, 2005)*

In addition to Eagle’s Integrative Model for Brief Term Intervention in the Treatment of Psychological Trauma (adopted and adapted from Eagle, 1998) and still focusing on the topic of TOP, I have adopted and adapted, for inclusion in the package of practice guidelines, a programme referred to as **“The Journey: a road to post-abortion recovery”**. This programme was developed by Thompson in 2005 and is based on Freed and Salazar’s (1993:48) “Healing Steps to post-abortion recovery”. This is presented next, as it provides some practical pointers for post-abortion counselling, in order to assist the student on her journey to healing and recovery following her decision to terminate her UP.

This programme addresses PAS by working through the PAS symptoms, as well as the grieving process resulting from the loss. Emphasis is placed on the grief cycle, based on the well-known “five stages” model popularised by Elisabeth Kübler-Ross in her seminal book “On death and dying” (Kübler-Ross, 1969:51), as well as healthy and unhealthy ways of grieving, with the latter often being the result of ambivalence about the nature of the loss caused by a TOP. The necessity of grieving the loss resulting from a TOP, in other words resolving and reconciling the loss through a healthy grieving process, is emphasised. The difference between healthy and unhealthy grieving is depicted in Figure 6.1.

Unhealthy Grieving

An event happens that brings up a memory of the TOP, such as a news report, pregnant woman, baby, anniversary date, etc.



Healthy Grieving

An event happens that brings up a memory of the TOP, such as a news report, pregnant woman, baby, anniversary date, etc.

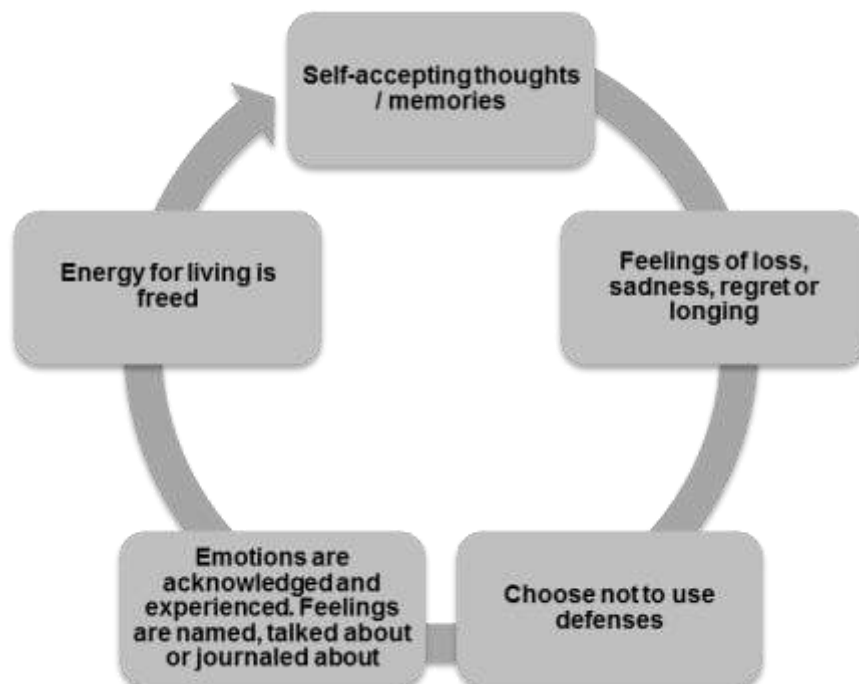


Figure 6.1: Unhealthy grieving versus healthy grieving (Thompson, 2005:208)

The process of facilitating healing after a TOP through the grief cycle, as depicted in the figure above, constitutes the foundation of ***“The Journey: a road to post-abortion recovery”*** (Thompson, 2005), hereafter referred to as “The Journey”.

This programme consists of the following eight steps:

- ✓ *Step one* refers to ***overcoming denial*** and entails dealing with the reality of the TOP-experience, as denial thereof is seen as an illegitimate way of coping with the trauma. This step involves a gradual process of guiding the woman to accept that the TOP has affected her life and an awareness that she needs to confront the reality and learn to live with the truth and the loss (Thompson, 2005:210; Freed & Salazar, 1993:48).
- ✓ *Step 2* refers to the ***recognition of real feelings and real losses*** and involves an acknowledgement of the emotions related to the TOP. The process of grieving is facilitated by naming the losses suffered as a result of the TOP (Thompson, 2005:210; Freed & Salazar, 1993:49).
- ✓ *Step 3* refers to ***cancelling empty deals***, which involves the acknowledgement of bargaining and other coping mechanisms in order to suppress feelings (Thompson, 2005:210; Freed & Salazar, 1993:49).
- ✓ *Step 4* refers to ***unlocking the trapdoor of guilt and shame***. These feelings negatively impact on the healing process and therefore this step consists of:
 - ❖ recognition of the difference between shame and guilt;
 - ❖ recognition of the decisions made regarding the TOP, as well as acceptance of responsibility of these decisions; and
 - ❖ acquiring (new) skills to live within healthy boundaries (Thompson, 2005:210; Freed & Salazar, 1993:49; 88).
- ✓ *Step 5* refers to ***taking the lid off*** and involves the acknowledgement that post-abortion anger is a “pressure cooker that gives the illusion of power and hides deeper pain” (Thompson, 2005:210; Freed & Salazar, 1993:49). The

importance of learning to express these feelings of anger in a constructive manner is emphasised.

- ✓ *Step 6* refers to ***working through depression and not surrendering to it***. This requires a commitment to “not surrender to crippling depression” (Freed & Salazar, 1993:49), as well as the acknowledgment that long-term depression over the TOP robs one of emotional energy and the ability to live a healthy, productive life (Thompson, 2005:210).
- ✓ *Step 7* refers to ***finding freedom in forgiveness***. The importance of offering and receiving forgiveness is stressed. This entails that the TS should forgive herself and/or others (Thompson, 2005:210; Freed & Salazar, 1993:50). The SP should in this regard emphasise that forgiveness is a choice and a conscious decision, and that it ultimately impacts on the wellbeing of the student (Freed & Salazar, 1993:120). The student should be guided to identify possible hindrances to forgiveness, such as holding on to anger, justifying behaviour (for example by saying that she “cannot forgive because she cannot forget”) (Freed & Salazar, 1993:121), or the belief that forgiveness should be earned.

The following practical tool to encourage and facilitate the process of forgiveness is suggested: the student should be requested to keep a journal in which she could make a list of who and/or what she wants/needs to forgive, for example: “I want to forgive my mom for forcing me to go for an abortion.” Her feelings (such as anger) toward these people (and/or events) should be noted, as well as possible reasons/factors hindering/preventing her from forgiving them. Once she has set her will to forgive, she should take her list and state her forgiveness, for example by saying out loud: “Mom, I forgive you for not supporting me and insisting that I go for an abortion.” Once she has forgiven all the people/events on her list, she should destroy it. This will ensure her privacy and serve as a symbolic gesture about her decision to forgive and release herself from the past. The SP can follow-up with her in a future session to confirm that she has indeed reached closure in this regard (Freed & Salazar, 1993:125).

- ✓ *Step 8* refers to ***becoming reconciled*** and involves “closure, integration and embracing life in its fullest sense” (Freed & Salazar, 1993:129). Having grieved the loss she experienced through the TOP and having taken back her life, the student can now focus her attention on the present by reclaiming, amongst others, her new self-acceptance (Thompson, 2005:2; Freed & Salazar, 1993:50).

The presentation of the strategies to intervene in the PAS experienced by the TS who chose TOP as an option to manage her UP is herewith concluded, as is the presentation of the guidelines for psychosocial support to TSs presenting with an UP and/or TOP.

6.3.7 Conclusion

The practice guidelines for psychosocial support to assist SPs in their service delivery to TSs presenting with an UP and/or TOP, presented in this section, relates to “what” SPs should/could do and “how” to do it. SPs should however take note that the set of guidelines offered is but one way of providing support to said client system group – it is not the only way. It is therefore suggested that SPs should feel free to adapt the suggestions proffered to suit their own style, unique needs, and circumstances.

6.4 CHAPTER SUMMARY

In this chapter, the practice guidelines that were developed with the purpose of assisting SPs in their service delivery to TSs presenting with an UP and/or TOP were presented. The content of the guidelines was based on literature and the research findings of this study, namely the experiences, needs, and suggestions for psychosocial support of the TS-participants who presented with an UP and/or TOP (presented in Chapter Four), as well as the perceptions of the SP-participants about the experiences and needs of students presenting with an UP and/or TOP, the scopes of services offered to them, and their suggestions for the provision of psychosocial support to such students (presented in Chapter Five).

The practice guidelines were developed from a social work perspective. Presentation thereof was preceded by an overview of the policy frameworks and legislation underpinning it, which included the White Paper for Social Welfare (1997); the ISDM for Developmental Social Services (DSD, 2005); the Framework for Social Welfare Services (DSD, 2013); the National AYHP 2017 (DoH, 2017); the NAFCI (Ashton et al., 2009); and the CTOP Act No 92 of 1996 (South Africa, 1996).

The focus of the practice guidelines was firstly on suggestions for establishing a therapeutic relationship with the TS presenting with an UP and/or TOP. The purpose and function of the psychosocial support provided to TSs presenting with an UP or TOP and the prerequisite knowledge base required by the SP in this regard were also presented, with the suggestions offered in this regard being followed by guidelines for assessing and intervening in the features known as the 4S-system in Schlossberg's Transition Process Model (Schlossberg, 2011:160-161), namely the situation, the self, the support, and the coping strategies surrounding the TSs' UP and/or TOP. An assessment tool for exploring and appraising the biopsychosocial functioning and wellbeing of the TS presenting with an UP and/or TOP was presented, as well as suggestions for intervening in the presentation of the UP. Practice guidelines for reflecting on the decision taken by the TS to manage the UP and the outcome thereof were also offered.

The concluding chapter of this study consists of a review of the study and conclusions and recommendations made based on the research findings, the research process, and the developed guidelines.

CHAPTER SEVEN: SUMMARIES, CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS

7.1 INTRODUCTION

This study has been about the proffering of practice guidelines to assist SPs in their service delivery to TSs presenting with an UP and/or TOP. In Chapter One, I informed the reader of the concern I noticed in my day-to-day social work service delivery to TSs about the increase in and detrimental effect of UPs and TOP on the students, their significant others, and the tertiary institutions.

This concern served as impetus to embark on a research journey with one of the goals being to explore the experiences, support, and support needs of TSs presenting with an UP and/or a TOP from the perspectives of such students and the SPs rendering services to them. Initially, I undertook a literature search to familiarise myself about the current state of knowledge on this as a chosen topic to study. This led me to arrive at a two-pronged conclusion:

- A plethora of information exists about the factors contributing to the phenomenon of UPs and/or TOPs, as well as the consequences thereof (Kilwein & Looby, 2017:102; Shahry et al., 2016; Calvert et al., 2013; Picavet et al., 2013:328; Wheeler et al., 2012:154) (see Section 1.1.1 & 1.1.2).
- There is a lacuna in the body of knowledge available with specific reference to practice guidelines from the ambit of social work or any other related disciplines, such as psychology and nursing, directed specifically at offering psychosocial support to TSs presenting with an UP and/or TOP, with such practice guidelines being informed by the student's experiences and needs; SPs' perceptions of these experiences and needs; the scopes of the support services they offer to said students; as well as the suggestions offered by both the TS- and the SP-participants for informing practice guidelines for psychosocial support.

The conclusions that emerged from the literature search undertaken led to the following research problem being formulated for the study, which resonates with what Creswell (2016:88) labels as "real-life" and "literature-related" problems:

The prevalence of and increase in UPs and TOPs is a real-life problem, with detrimental effects on the students, their significant others, and tertiary institutions. In addition, there is a stillness in the literature with reference to practice guidelines for psychosocial support from the ambit of social work to assist SPs in their service delivery to TSs presenting with an UP and/or TOP. The development of such guidelines should be informed by and based on the experiences, needs, and suggestions of TSs who have had an UP and/or TOP, as well as the perceptions and suggestions of SPs rendering psychosocial support services to said students.

Flowing from the identified research problem, I formulated two sets of research questions, focusing on the TSs and the SPs (see Section 2.2). The research questions consequently guided the research process towards the realisation of two sets of goals that were formulated for the study. The first set of goals, pertaining to the TSs, was to develop an in-depth understanding of the experiences, support, and support needs of TSs who had an UP and/or a TOP, and to gather suggestions from them about how students in such a predicament should be supported in view of proffering guidelines for psychosocial support to TSs presenting with an UP and/or a TOP. The second set of goals focused on the SPs rendering support services to students presenting with an UP and/or TOP with the aim of obtaining their perceptions and understanding about the experiences and support needs of these students; the scopes of the support services they offer to such students; and to request suggestions on how to provide psychosocial support to these students in view of proffering practice guidelines for this purpose.

The aforementioned aspects formed part of a research plan (included in Chapter Two of this thesis) which I submitted to the Departmental Research and Ethics Committee of the Department of Social Work at UNISA for approval and ethical clearance. Once permission to conduct my research was obtained, I proceeded with the operationalisation of my research plan, which included the recruitment, screening, and selection of the research participants, as well as preparing them for data collection, which I approached in an ethical and responsible manner. The process of data collection and analysis followed next, with the data analysed being presented in Chapter Four and Chapter Five of this report. A discussion of how my research plan was applied is presented in Chapter Three.

In this chapter, which is the concluding chapter of my thesis, the information presented with regard to the general introduction and orientation to the study, the proposed and applied research methodology, the research findings and the practice guidelines proposed for the provision of psychosocial support to TSs presenting with an UP and/or TOP will be summarised. The conclusions arrived at as a result of this endeavour will be presented, the limitations inherent to the study highlighted, and recommendations with specific reference to how to market the practice guidelines through further education and training and continuous professional development activities, as well an agenda for future research, will be provided.

7.2 CHAPTER-WISE SUMMARY AND CONCLUSIONS

The following sections consist of a summarised overview of each of the chapters of this research report, with the conclusions indicating the contribution of each chapter towards reaching the goals of this study.

7.2.1 Summary and conclusions for Chapter One: General introduction and orientation to the study

This Chapter was devoted to setting the stage for the research (Creswell, 2016:881; 1994:21) by providing background information on and introducing the topics of UP and TOP. These topics were introduced by looking at them generally and then narrowing the focus on what the consulted literature revealed about these phenomena as they relate to TSs in particular. In addition, I included in this Chapter the rationale for the study and theoretical framework adopted to underpin this undertaking.

Concerning the phenomenon of an UP, the incidence and escalation thereof, the contributing factors, disadvantages, negative consequences, and detrimental impact thereof on the TS, her significant others, and the tertiary institution were discussed. The decision-making process, with specific reference to the options available when confronted with an UP, namely parenting, adoption, foster care, or TOP, was introduced and the aspect of TOP further elaborated upon.

Trends noticed from the literature review on the UP phenomenon, which were corroborated with the feedback received from SPs rendering services to TSs presenting with an UP and/or TOP on this topic (see Section 4.3.1; 4.3.2; 5.3.1 & 5.3.2), brought me to the following conclusions:

- The prevalence of and increase in UPs amongst TSs, both nationally and internationally, is a serious social concern especially given the consequences and costs it has for students, their significant others, and tertiary institutions (Bongaarts & Casterline, 2013:143, Akintade et al., 2011:74).
- Both the literature consulted and the SPs' informal feedback pointed to the fact that ignorance about and negative attitudes concerning contraception, engaging in high-risk sexual behaviour, peer pressure, and limited access to resources often lead to UPs (Shahry et al., 2016; Calvert et al., 2013).
- For a TS to experience an UP is disadvantageous and has many negative consequences (Mantell et al., 2015:1134; Upadhya & Ellen, 2011:538) and this event often coincides with other transitions such as the educational transition from secondary to tertiary education, and the transition from adolescence/late adolescence to adulthood (Kilwein & Looby, 2017:102; Lane, 2015:30).

From the literature consulted to set the stage for this research, I arrived at the conclusion that for TSs, an UP is generally appraised and experienced as a crisis, with this event being described as stressful and traumatic, disrupting the equilibrium of the student's academic, social, relationship and family life (Tabane & Mmapheko, 2015:2; Daley, 2012:38; Adams & Williams, 2011:1870). This conclusion was subsequently confirmed by the both the TS and SP-participant groups.

As for the decision on how to manage an UP, the information that I gathered from the literature consulted led me to conclude that none of the available options are easy and that such a decision-making process tends to be influenced by pressure from different areas and/or people, such as academic pressure, financial pressure, pressure from significant others, or the lack of support from her significant others. The decision that the student makes in one set of circumstances might not be the same one that she would make at a different stage or time in her life (Grey, 2015:737; Bezuidenhout, 2004:38).

In Chapter One the phenomenon of TOP was also introduced by indicating the occurrence thereof as one of the ways to manage an UP. The prevalence of and increase in TOPs, the aspect of multiple TOPs, the factors influencing the TOP-decision, and the experiences and consequences of a TOP were discussed.

In reflecting on the literature on the topic of TOP, and the feedback received from SPs rendering services to TSs presenting with an UP and/or TOP based on questions put to them informally, I came to the conclusion that the option to terminate a pregnancy is seen as a 'quick-fix' to get one's life back on track and to get rid of the unwanted pregnancy, making this a rather attractive and common option (Hodes, 2016:80). This results in high TOP-rates (Curley & Johnston, 2013:281) being documented amongst TSs. Although the promulgation of the CTOP Act 92 of 1996 (South Africa, 1996) and the CTOP Amendment Act 38 of 2004 (South Africa, 2005) resulted in a reduction in the number of unsafe TOPs (Hodes, 2016:82), I arrived at the conclusion that high rates of unsafe TOPs are still prevalent amongst students (Hodes, 2016:83; Lince-Deroche et al., 2015:342; Wheeler et al., 2012:157). The shame associated with and/or fear of stigmatisation or judgement still prevails, with the latter preventing a safe TOP from being considered as an option to manage an unwanted pregnancy (Mosley et al., 2017; Lince-Deroche et al., 2015:342; Harries et al., 2014:16).

Of particular interest to me was the prevalence of and increase in multiple TOPs, in other words women having two or more TOPs, which has risen to its highest level ever worldwide (Picavet et al., 2013:328; Rowlands et al., in Rowlands, 2014:197). From the literature consulted this trend is also prevalent amongst TSs (Mphatswe et al., 2016:153; Pestvenidse et al., 2016:85; Mavis et al., 2015:1154). The explanation offered for the occurrence of this phenomenon is the relative ease with which the CTOP Act 92 of 1996 (South Africa, 1996) facilitates TOPs, which in turns fosters a careless attitude amongst TSs towards contraception and the TOP-procedure (Pestvenidse et al., 2016:87). In the context of tertiary education, where an UP could lead to the student not completing her studies, a TOP could be used as a form of emergency contraception (Mphatswe et al., 2016:153).

In terms of the factors determining the TOP-decision amongst TSs, I came to the conclusion that this decision is a complex one influenced by the over-arching motivation that a TOP would assist the student in delaying the transition to parenthood, thus increasing her chances of continuing with and completing her studies (Pestvenidse et al., 2016:87; Panday et al., 2009:25). Aspects influencing students' decision to terminate their UPs, provided by the literature consulted, is pressure from their partners or parents to terminate the pregnancy (Mavis et al., 2015:1155; Ralph et al., 2014:430), financial pressure (Macleod et al., 2016:1101; Mphatswe et al., 2016:155), and fear of social condemnation (Mavis et al., 2015:1154; Macleod & Tracey, 2009:13). I concluded that, for the TS confronted with an UP, a TOP might be seen as a quick, easy, affordable, and secret way to deal with the UP-crisis (Gomez-Scott & Cooney, 2014:651). In terms of the TOP-procedure however, I arrived at the conclusion that the majority of students who consider this option seem to be lacking comprehensive and accurate information regarding the procedure and they therefore seldom are prepared for the possible emotional trauma or psychosocial consequences resulting from this experience (Macleod et al., 2016:1102; Lince-Deroche et al., 2015:340).

Although studies on the psychological consequences of a TOP have had conflicting results, with several scholars finding no evidence that the experience of a TOP could be associated with aspects such as depression, anxiety, low self-esteem, guilt, shame, and sadness (Biggs et al., 2014:2512; Warren et al., 2010:231), I came to the conclusion that the impact that a TOP has on the psychological life of the woman who makes this choice usually goes unheard and without acknowledgement that she may have struggled with her decision, felt bereft as a result thereof, or that the experience may have left her traumatised (Bradshaw & Slade, 2013:932). I found Miller's Theoretical Model of the Psychological Antecedents of Abortion (Miller, 1992:67) to be of particular value and significance, as it confirms and explains that a TOP has short-term and long-term psychological consequences. His explanation led to the development of the concept "post-abortion stress" (Curley & Johnston, 2013:283) which acknowledges that a TOP is regarded as a significant and prevalent transition in a woman's life, resulting in a type of PTSD (Rocca et al., 2015; Bradshaw & Slade, 2013:934). The experience of post-termination sequelae, characterised by depression, feelings of regret, guilt and anxiety, by women who

have terminated their UPs, has been confirmed by literature, with PAS including psychological disturbances such as nightmares, anger, suicidal ideation, and isolation, as well as behavioural disturbances such as avoiding babies and pregnant women, promiscuity, relationship problems, and physical tension (Rocca et al., 2015; Harries et al., 2014:16; Bradshaw & Slade, 2013:934). I therefore concluded that healing after a TOP is a unique challenge, because the experience and consequences thereof are the result of a choice she has made (Mavis et al., 2015:1153; Bradshaw & Slade, 2013:936).

Consultation of the literature in order to provide a backdrop and set the scene for the study (Creswell, 1994:21) led me to the conclusion that TSs presenting with an UP and/or TOP are a client system group in need of support and assistance, but that tailor-made initiatives (as discussed earlier in this chapter - see Section 7.1) targeted at the provision of psychosocial support, based on and informed by the experiences and support needs of said students, were lacking in practice. This state of affairs informed my motivation for this study, which was highlighted and elaborated upon in Chapter One. In terms of the rationale for this study, I can conclude that, through this endeavour the following were contributed:

I was able to add to the body of knowledge available by contributing information on the experiences, support, and support needs of TSs presenting with an UP and/or TOP, as well as the suggestions for psychosocial support offered by them and the SPs rendering support services to them. I furthermore managed a contribution to social work practice through proffering practice guidelines for psychosocial support to students presenting with an UP and/or TOP aimed at SPs rendering services to such students. I was also able to provide an example of how to plan a qualitative research project (see Chapter Two) and how it was applied in practice (a description of this process was presented in Chapter Three of this thesis).

Subsequent to formulating and stating the research problem and rationale for the study, I introduced the theoretical framework that was adopted for this endeavour. The value and importance of a theoretical framework in the research process was indicated in that it serves as a foundation on which the study is built (Grant & Osanloo, 2014:13); it enables the researcher to make sense of what he/she sees;

serves as a spotlight illuminating a specific phenomenon; and is a tool (Thomas, 2017:99) for explaining a problem experienced by an individual or group in order to increase understanding about and give insight into the phenomenon (Maxwell, 2013:49; Neuman, 2012:26). Schlossberg's Model for analysing human adaptation to transition, also referred to as the Transition Process Model (Anderson et al., 2012; Schlossberg, 2011; Schlossberg, 1981) was selected for this purpose. This model, which has its origins in crisis theory (Moos & Tsu, in Schlossberg, 1981), assisted me to develop an in-depth understanding of and an insight into the TS's experience of her UP and/or TOP, and her unique support needs associated with this phenomenon. In reflecting on my utilisation thereof, I came to the conclusion that the Transition Process Model (Schlossberg, 1981) was particularly suitable as adopted theoretical framework for this study as it became, as per Maxwell's analogy (Maxwell, 2013:49), the proverbial coat closet in which I displayed my research findings in an orderly manner. The 4S-system underpinning Schlossberg's Transition Process Model, namely the *situation*, the *self*, the *support*, and the (coping) *strategies* (Anderson et al., 2012:39; Schlossberg, 2011:160-161) became what Maxwell refers to as the coat hooks in the closet upon which I hung my data to enhance its meaning. These facets were furthermore utilised to package the practice guidelines for the provision of psychosocial support to students presenting with an UP and/or a TOP, as the guidelines were organised according to Schlossberg's 4S-system.

7.2.2 Summary and conclusions for Chapter Two: The proposed research plan – An introduction

This Chapter consisted of a discussion on how I planned to solve the identified research problem. In taking heed of the suggestion offered by Punch (2016:2), it was important for me to engage in a process of systematic and comprehensive planning which culminated in the development of a research plan which also, as indicated earlier in this Chapter (Section 7.1), was presented as part of my research proposal, submitted with the purpose of obtaining ethical approval and permission to conduct the research.

At the outset, research questions were formulated to address the identified research problem. In addition, research goals were formulated, with task and research

objectives in order to attain the goals. In the discussion to follow, the research questions, goals, and objectives are presented in a summarised fashion with conclusions being drawn to indicate if the questions were answered and the goals and objectives met.

As I proposed to sample participants from two interest groups, namely TSs who presented with an UP and/or TOP and SPs rendering support to these students, two sets of research questions were proposed for this study.

The first set of questions, focusing on the TSs, was as follows:

- *How did TSs experience their UPs and/or TOPs?*

This research question was answered in Chapter Four (see Section 4.3.1.3, 4.3.1.4 & 4.3.2.4) of this report. Based on the accounts of the TS-participants, I arrived at the conclusion that they experienced a wide range of negative feelings and emotional reactions upon the suspicion and confirmation of their UPs (Akbarzadeh et al., 2016:190; Barton et al., 2017; Tabane & Mmapheko; 2015:2). Feelings of shock, denial, and disbelief; worry and stress (about the reactions of others and their significant others, as well as worry and stress about their studies and the financial implications of the UP); and fear of loss of the relationship with their partners and significant others were experienced (Adams & Williams, 2011:1879; Van Breda, 2011:20). They also experienced feelings of guilt and shame, loneliness, withdrawal/isolation from others, disappointment (in herself, for allowing the UP to happen), sadness, and anger (mainly directed at herself, for allowing the UP to happen), as well as crying (Barton et al., 2017; Adams & Williams, 2011:1880). The experience of mixed and paradoxical feelings was also illuminated by one of the TS-participants who shared that she initially experienced fear and worry, but that she was also, to a certain extent, happy about her pregnancy (Ekstrand et al., 2009:175; Skinner et al., 2009:52).

I came to the conclusion that for the TS-participants who opted for parenting as option to deal with the UP, positive feelings such as relief, contentment, and happiness were experienced (Hall et al., 2017:1338; Adams & Williams, 2011:1891).

For the ones who chose TOP as option to deal with the UP, the emotions experienced afterwards were predominantly negative, confirming that the experience of their TOP is a traumatic and a life-changing event (Kjelsvik & Gjengedal, 2011:173; Steck, 2011:18-19). Feelings of sadness and grief, regret, resentment and anger (towards her significant other, for pressuring her to opt for a TOP), guilt, shame, loneliness, and isolation/withdrawal from others were experienced and expressed (Frederico et al., 2018:335; Steck, 2011:18).

From the TSs' accounts I arrived at the conclusion that the experience of the UP and/or TOP impacted their lives negatively (Barton et al., 2017; Adams & Williams, 2011:1880). Their relationships with significant others ended or became strained; their financial prospects became uncertain and caused stress; their academic performance deteriorated; and their future academic prospects became uncertain (Valois et al., 2013:38; Adams & Williams, 2011:1880). Only one student upon reflection shared that her UP-experience forced her to grow up and become responsible.

- *What support needs did TSs experience in relation to their UPs and/or TOPs and how were they supported?*

The answers to this question are presented in Chapter Four (see Section 4.3.3.1, 4.3.3.2 & 4.3.3.3) of this report. In reflecting on their accounts, I came to the conclusion that they sought and received on and off-campus professional and informal support in relation to their UPs and/or TOPs. Medical and/or counselling formed part of on-campus professional support sought and received (Kaur, 2016:127; Van Breda, 2011:24). The off-campus professional support utilised by the students included the medical services of private general practitioners, as well as counselling support offered to them by volunteer counsellors at a CPCC (Rahman et al., 2017:70; Kjelsvik & Gjengedal, 2011:172). I also learnt that the students were supported informally on campus by their friends and that their off-campus informal convoy of support included mainly maternal and partner support (Van Breda, 2011:iv; Ekstrand et al., 2009:173). One of the students shared that she received informal, on-campus support from one of her lecturers. In their reflections on how they experienced the received support, I came to the conclusion that it was experienced both in a positive

and a negative light. That is to say, they expressed positive experiences such as the support being helpful and beneficial (Van Breda, 2011:2) but, in the case of Participant D, the support received was experienced as negative and judgemental (Grey, 2015:737; Van Breda, 2011:20) (see Section 4.3.3.2).

The TSs' accounts in terms of support-needs disclosed the following. They need more information about the availability of on and off-campus support services and resources; more support from their significant others; and more information about the different options to choose from when confronted with an UP (see Section 4.3.3.3). Additional needs expressed in this regard were: the need to be better prepared for the TOP-process and procedure, and to be less afraid of what others are thinking or saying about the ordeal of an UP (see Section 4.3.3.3).

- *What are the TSs' suggestions for practice guidelines for psychosocial support to TSs presenting with an UP and/or a TOP?*

The suggestions forwarded by the TS-participants in response to this research question are presented in Chapter Four (see Section 4.3.4.1).

From their suggestions forwarded (see Section 4.3.4), which they based on the support and/or lack of support experienced in relation to their UPs and/or TOPs, it became clear that they needed medical support (especially on-campus medical support); counselling support (which should include crisis pregnancy counselling, pre and post-abortion counselling, as well as relationship and/or family counselling); and peer support (such as a peer support group for students dealing with an UP). Furthermore, they suggested awareness campaigns to inform students about UPs and TOPs and where to go to for assistance and support when confronted with this phenomenon. Suggestions for financial and academic-related support were also made (French et al., 2017:716; Aiken et al., 2015:149; Tabane & Mmapheko, 2015:4; Van Breda, 2011:20).

The second set of research questions, focusing on the SPs, was as follows:

- *What are the perceptions of SPs rendering support services to TSs presenting with an UP and/or TOP about the experiences and support needs of these students?*

The answers to this research question are presented in Chapter Five (see Section 5.3.2.1 & 5.3.2.2). The accounts based on the SP-participants' perceptions brought me to the conclusion that they perceive TSs presenting with an UP and/or TOP to experience feelings of –

- confusion and pressure about the UP and the management thereof;
- loneliness and lack of support;
- fear of the negative reactions of and abandonment by their significant others;
- guilt and shame;
- shock upon the confirmation of the UP;
- trauma, as a result of the TOP-procedure; and
- stress and pressure with regard to their studies and finances.

(Hall et al., 2017:1337; Tabane & Mmapheko, 2015:2; Adams & Williams, 2011:1880; Kjelsvik & Gjengedal, 2011:174).

I arrived at the conclusion that the SPs' views on the support needs of TSs are closely linked to the support needs articulated by the TS-participants. Counselling and on-campus medical support, as well as academic support, were mentioned (see Section 5.3.2.2).

- *What are the scopes of the support services offered by SPs to TSs presenting with an UP and/or a TOP?*

From the answers provided by the SP-participants to this question, which are presented in Chapter Five (see Section 5.3.3.1 & 5.3.3.2), I arrived at the conclusion that counselling support was offered, focusing on crisis pregnancy counselling, as well as post-abortion and bereavement counselling. As part of the counselling support, they refer students when necessary and when it is in the best interest of the student and they liaise with internal and external resources and the student's

significant others. Providing life skills and psycho-education also formed part of their counselling support. Concerning the provision of medical support, I learnt that such services included the provision of contraceptives and/or family planning services, pregnancy testing, and the provision of information on and education in sexual health matters focusing on topics such as the HIV, STDs, and the options available for managing an UP.

- *What are the suggestions of SPs rendering support services to TSs presenting with UPs and/or TOPs for informing practice guidelines for psychosocial support to said students?*

The suggestions forwarded by the SP-participants in response to this research question are presented in Chapter Five (see Section 5.3.5.1 & 5.3.5.2). Their suggestions included a recommendation that psychosocial support to TSs presenting with an UP and/or TOP should be provided through individual counselling, group work, and community outreaches. During these endeavours, the following aspects should be focused on and addressed: crisis pregnancy and pre and post-abortion counselling; self-esteem; relationships; parenting; financial management; sexuality, sexual health and contraception; as well as information and awareness regarding the availability of resources and the options to manage an UP. They also suggested that psychosocial support to the said students should be enhanced through better networking, cooperation and referrals between tertiary institutions, significant others and community resources. Additionally, they recommended that the practice guidelines for the provision of psychosocial support should be user-friendly, holistic, flexible, and disseminated to all relevant role players. Other suggestions were that the guidelines should aim to inform tertiary institutions' policies with regard to student pregnancy and that SPs rendering support services to TSs with an UP and/or TOP should receive specialised and on-going training, specifically related to the phenomenon of UPs and TOPs.

The information obtained from the TS- and SP-participants, summarised above and presented as research findings in Chapter Four and Five, led me to conclude that the all of the research questions formulated to guide this research endeavour were answered.

Two sets of goals emanated from the research questions (see Section 2.3), with the first set aiming to answer the research questions pertaining to the TSs and the second set of goals answering the research questions with reference to the SPs. Concerning **the first set of goals**, and upon reflection, I arrived at the conclusion that the stated goals were met, as (1) I obtained an in-depth understanding of the experiences, support, and support needs of TSs who had an UP and/or a TOP (the outcome of this endeavour was put on record in Chapter Four of this thesis) and (2), I was able to proffer practice guidelines to SPs for psychosocial support to TSs presenting with an UP and/or TOP. These practice guidelines, presented in Chapter Six of this report, were, in part, based on and informed by the experiences, needs, and suggestions of the TS-participants, with the purpose of assisting SPs in their service delivery to TSs presenting with an UP and/or TOP.

As far as **the second set of goals** was concerned, pertaining to the SPs, I can conclude the stated goals were realised. I managed to obtain an in-depth understanding of the perceptions of the SPs rendering support services to TSs presenting with an UP and/or TOP regarding the experiences and support needs of said students. I furthermore gained insight into the scopes of the support services offered by the SPs to TSs presenting with an UP and/or TOP. All these aspects explored were described and presented in Chapter Five of this thesis. This information gathered, together with the suggestions for psychosocial support to TSs with an UP and/or TOP, enabled me to formulate and proffer practice guidelines which were interspersed with the TS-participants' suggestions and were presented in Chapter Six of this report.

To assist with the goals formulated for this study, a number of task and research objectives were formulated. These are recapped in Table 7.1 and accompanied by cross-references to sections in this research report indicating how and where these objectives were operationalised or met. This indication serves as a confirmation of my conclusion that I managed to meet the stated objectives.

Table 7.1: Summary of the task and research objectives formulated for this study and the conclusion on the realisation thereof

TASK OBJECTIVES	RESEARCH OBJECTIVES
<ul style="list-style-type: none"> To obtain a sample of TSs who have experienced an UP and/or TOP <p>In confirmation of how this objective was met, the reader is advised to revisit Chapter Three (Section 3.5.1. and 3.5.2) for the account on how I obtained a sample of TSs presenting with an UP and/or TOP within the geographically demarcated population.</p>	
<ul style="list-style-type: none"> To conduct in-depth, semi-structured, face-to-face interviews with the sampled TSs <p>This objective was met and in verification thereof, the reader is advised to revisit Section 2.5.2 and 2.5.3 for details on how I planned to prepare the TSs for the process of data collection, the method of data collection (in-depth, semi-structured, face-to-face interviews) to explore the aspects of concern, and the questions and requests to facilitate such exploration. For a descriptive account on how this plan was applied, the reader is referred to Section 3.5.3.</p>	<ul style="list-style-type: none"> To explore the TSs' experiences, support, and support needs in relation to their UPs and/or TOPs, and based on and in addition to these, invite suggestions to inform practice guidelines for psychosocial support to students presenting with an UP and/or a TOP
<ul style="list-style-type: none"> To obtain a sample of SPs rendering support to TSs with UPs and/or TOPs <p>A descriptive account testifying how this objective was realised is to be found in Section 3.5.1 & 3.5.2.</p>	
<ul style="list-style-type: none"> To conduct focus group discussions with the sampled SPs <p>This objective was met and in verification thereof, the reader is advised to revisit Section 2.5.2 for details on how I planned to prepare the SP-participants for the process of data collection, the methods of data collection (focus group discussions and semi-structured interviews) that I adopted to</p>	<ul style="list-style-type: none"> To explore - <ul style="list-style-type: none"> SPs' perceptions of TSs' experiences and support needs related to UPs and TOPs; the scopes of the support services offered by SPs to TSs presenting with an UP and/or a TOP; and SPs' suggestions to inform practice guidelines for psychosocial

explore the aspects of concern, and the questions and requests to facilitate such exploration. For a descriptive account on how this plan was applied, the reader is referred to Section 3.5.3.	support based on their perceptions of the experiences and needs of students with UPs and/or TOPs, as well as the scopes of the support services offered to said students.
<p>- To sift, sort, and analyse the data obtained from the TSs and the SPs using Tesch's eight steps for qualitative data analysis as cited in Creswell (2014:198)</p> <p>Tesch's eight steps (in Creswell, 2014:198) were introduced in Chapter Two (Section 2.5.5) as part of the research plan. A descriptive account on how they were applied in the process of data analysis is to be found in Chapter Three (see Section 3.5.4).</p>	
	<ul style="list-style-type: none"> • To describe the explored – <ul style="list-style-type: none"> - experiences, support, and support needs of TSs in relation to their UPs and/or TOPs, and the suggestions based on these to inform practice guidelines for psychosocial support to students presenting with an UP and/or a TOP; - SPs' perceptions of TSs' experiences and support needs related to UPs and TOPs; - scopes of the support services offered by SPs to TSs presenting with an UP and/or a TOP; and - suggestions forwarded by SPs to inform practice guidelines for psychosocial support to students presenting with an UP and/or TOP based on SPs' perceptions of these students' experiences and needs to develop such practice guidelines. <p>A detailed description of these aspects as the research findings is presented in Chapter Four and Five.</p>
<ul style="list-style-type: none"> • To conduct a literature control to verify the findings <p>The data that was obtained from the research participants were thematically analysed. The themes, sub-themes, and categories that emerged as a result of this process were substantiated by direct participant quotations. Existing</p>	

<p>literature was used to confirm or contrast the thematic research findings. In confirmation of this objective testifying to the fact that a literature control was conducted, the reader is advised to revisit Chapter Four and Five where the research findings are presented.</p>	
<ul style="list-style-type: none"> • To provide an overview of the legislative and policy frameworks informing the provision of psychosocial support to women presenting with UPs and/or TOPs and underpinning the practice guidelines proffered for the provision of psychosocial support to TSs presenting with an UP and/or a TOP <p>The legislative and policy frameworks applicable specifically to the practice guidelines proposed were introduced in the beginning of Chapter Six, which also covers the practice guideline suggestions based on the literature and empirical research from this study.</p>	
	<ul style="list-style-type: none"> • To draw conclusions on – <ul style="list-style-type: none"> – the experiences, support, and support needs of TSs in relation to their experience of an UP and/or TOP, as articulated by the mentioned students and based on the perceptions of SPs rendering support to them; and – the scopes of services offered by SPs to TSs presenting with an UP and/or a TOP. - To make recommendations based on and informed by the empirical and literature search undertaken on – <ul style="list-style-type: none"> - the experiences, support, and support needs of TSs presenting with an UP and/or TOP; - the experiences and support needs of TSs with an UP and/or TOP from the vantage point/perception of SPs rendering support services to these students; - the scopes of support services offered by SPs to TSs presenting with an UP and/or a TOP; and - the suggestions forwarded by both the TS- and SP-participants by proffering practice guidelines for psychosocial support to

	<p>assist SPs in their service delivery to TSs presenting with an UP and/or a TOP.</p> <p>The current chapter, focusing on the conclusions arrived at and the recommendations forwarded, serves as a testimony of the realisation of this research objective, together with Chapter Six, which consists of the practice guidelines to SPs for psychosocial support to TSs presenting with an UP and/or TOP.</p>
--	--

The research plan introduced in Chapter Two also consisted of an introduction to the methodology proposed for conducting this study. A qualitative research approach was proposed and adopted. In order to remain true to the qualitative research approach intended for this endeavour, the collective instrumental case study and phenomenological research designs, as well as an explorative, descriptive, and contextual strategy of inquiry, were proposed and adopted. The research methods proposed for this research study were furthermore introduced, with reference to the aspects of the research population, sampling, participant recruitment, preparation for and methods of data collection, analysis, and verification. Lastly, the ethical principles deemed relevant for this study, namely informed consent, avoidance of harm, and the right to privacy, confidentiality of data, and anonymity, were introduced with a discussion of how I intended to uphold these principles.

Preparing this research plan which, according to Punch (2016:2), is the first phase of the research process and relates to the launch of the project, was a time-consuming and challenging process. However, while drafting the plan, I became aware of the value and importance thereof. This process led me to the conclusion that the research plan not only lays the foundation for, but also determines the success of a research project.

The next section of this chapter will consequently be devoted to a summarised overview of how the mentioned aspects/the research plan were applied during my fieldwork in view of realising the goals formulated for this study.

7.2.3 Summary and conclusions of Chapter Three: Description of the application of the research methodology utilised in this study

At the outset of Chapter Three I provided my defence for why I deemed it necessary to devote a whole chapter of this thesis to a description of how the research plan was operationalised. Firstly, this was done to provide an audit trail consisting of evidence and a systematic account detailing the research approach, design, and methods, as

well as a reflection on the choices and decisions taken, and how I arrived at my interpretations (Lietz & Zayas, 2010:196; Bowen, 2009:305). Secondly, my aim was to inform the reader how the research plan, commonly referred to in the context of qualitative research as a “rough sketch” (Devers & Frankel, 2000:253), was adapted in order to demonstrate that this study was carried out with care and that the research process was “logical, traceable and clearly documented” (McBrien, 2008:1287). A thick description of the methodology and the phenomenon that were studied was consequently provided in order to promote the credibility of the study (Shenton, 2004:69).

This defence was followed by a discussion in which I introduced the qualitative research approach as the approach adopted for the study and expanded on the characteristics underpinning it (see Section 2.4.1), as what this approach is all about and its distinctive characteristics informed my decision to utilise it for this research undertaking. Upon reflection and conclusion, the explorative aim of qualitative research (D’Cruz & Jones, 2014:21; Rubin & Babbie, 2013:95; Morrow, 2007:211) facilitated a process which enabled me to embark on an in-depth exploration of the experiences, support, and support needs of TSs presenting with an UP and/or TOP. It also assisted me to explore the perceptions of SPs rendering support services to TSs with UPs and/or TOPs about the experiences and needs of said students; to gain information about the scopes of the services offered by them to these students; and to obtain suggestions from both participant groups to inform the practice guidelines I proposed for the provision of psychosocial support for TSs presenting with this phenomenon.

Working from a qualitative research approach sensitised me to acknowledge and to take into account the context surrounding the issue being investigated, as qualitative research is conducted in a natural setting (Creswell, 2014:107-108; Hennink et al., 2011:110; Yin, 2011:13). As this approach advocates smaller samples, with participants being purposively recruited (Creswell, 2016:7; Wu et al., 2016:498; Yilmaz, 2013:313), I was able to identify two population groups. From these

populations, I managed to recruit a total of six TSs and 23 SPs, who, upon screening, met the inclusion criteria formulated for this study. I was the key instrument in the process of data collection (Creswell, 2014:185; Yilmaz, 2013:317), which was conducted in the field at the site where the participants experienced the problem, namely at the tertiary institutions where the students were registered and the SPs were employed, as well as the CPCC where the volunteer counsellors were rendering services to TSs presenting with UPs and/or TOPs.

The focus of the qualitative data collection process is to illicit stories and descriptions, looking for themes in the accounts shared (Creswell, 2014:186; Lichtman, 2014:45; Yilmaz, 2013:317). Through following a process of inductive reasoning (Rubin & Babbie, 2013:369), the transcriptions of the interviews and focus group discussions conducted were analysed and interrogated, to crystallise and consolidate themes, sub-themes, and categories emerging from the data based on the participants' accounts of the concerns that were explored. The descriptive nature of the qualitative approach (Creswell, 2014:154; Mathani, 2004:57) and the fact that it allows for flexibility in terms of writing and reporting (Lichtman, 2014:45; Rubin & Babbie, 2013:51) enabled me to observe and explore the phenomenon of UPs and TOPs and to carefully and deliberately describe it.

As mentioned earlier in this report (see Section 1.2 & 1.3), the topic chosen for investigation in this endeavour was under-researched and ill-defined (Creswell, 2016:8; Dempsey et al., 2016:480; Ritchie & Lewis, 2005:32033). With qualitative research by nature being interpretive, naturalistic, emergent, and inductive (Thomas, 2017:110; Yilmaz, 2013:312; Yin, 2011:7), I arrived at the conclusion that adopting this approach for investigating the experiences, support, and needs of TSs presenting with UPs and/or TOPs was particularly appropriate. The approach was also well-suited for exploring both the TSs' and the SPs' suggestions in view of informing the proposed practice guidelines for psychosocial support to assist SPs in their service delivery to TSs presenting with this phenomenon. The noticeable lacuna in the existing body of literature and empirical research with regard to guidelines for support

(elaborated upon in Section 1.2 & 1.3); the fact that the phenomenon can be labelled a “real-life” problem (Creswell, 2016:88); and the students presenting with the phenomenon of an UP and/or a TOP finding themselves in a vulnerable position where they can, as result of this experience, be stigmatised, ostracised, and even victimised, drew me to qualitative research, as it allows for investigating topics of a sensitive nature, involving vulnerable groups (Dempsey et al., 2016:480).

In terms of the research designs that were utilised in this study, I employed the collective instrumental case study design and the phenomenological research design, as well as an explorative, descriptive, and contextual strategy of inquiry, all of which are viewed as qualitative research designs (Lichtman, 2014:99).

The application of the collective instrumental case study design enabled me to engage with multiple sources (namely TSs and SPs) within the context of higher education, by means of different data collection methods (namely in-depth, semi-structured, face-to-face individual interviews, focus group discussions, and semi-structured individual interviews) to gain an in-depth understanding of and insight into the experiences, support, and support needs of TSs presenting with an UP and/or TOP (Thomas, 2016:172; Wahyuni, 2012:72; Creswell et al., 2007:236). In reflecting on the utilisation of this design, I came to the conclusion that it was well-suited given the goals that were formulated for this study. These were to gain insight into the phenomenon being investigated and to gather suggestions to inform the formulation of practice guidelines for offering psychosocial support to students presenting with an UP and/or TOP. As result and for this reason, the collective case study design was employed instrumentally for the purposes mentioned (Thomas, 2016:121; Snow et al., 2009:234).

My application of transcendental phenomenology, with the purpose of extracting the essence of the TS-participants’ lived-experiences, led me to conclude that this design was also particularly well-suited for this study as it enabled me to achieve a deepened, comprehensive understanding of the meanings that they attached to their

experiences (Yates & Leggett, 2016:229; Finlay, 2012:176; Tufford & Newman, 2012:84).

In reflecting on my incorporation of the explorative, descriptive, and contextual strategies of enquiry as part of the qualitative research design, I arrived at the conclusion that it was fitting as it assisted me to address the research questions and attain the research goals. It afforded me the opportunity to explore the “breadth and scope” (Bless et al., 2013:57) of the experiences, support, and support needs of TSs; the perceptions of the SPs about the experiences and support needs of said students; the scopes of support services offered by the SPs; as well as both groups’ suggestions for psychosocial support, which I described with the purpose of providing a comprehensive picture thereof (see Chapter Four and Five). In terms of the contextual strategy of enquiry, I followed the advice of Hennink et al. (2011:288) by describing the settings where I collected the data, as well as the logistics and challenges accompanying this process. I furthermore provided a description of the theoretical framework that was adopted for this study, namely Schlossberg’s Transition Process Model (Schlossberg, 2011 & 1981). The latter, which provided the theoretical context for the study, also became the background which the research findings were imbedded in and the organising framework (Wu et al., 2016:498; Maxwell, 2013:49; Hennink et al., 2011:288) for the formulated practice guidelines for psychosocial support suggested.

In reflecting on the research methods that were applied, with reference to the activities of determining the study’s population and the sampling process and techniques, I remained with the geographically demarcated population initially defined for this study. The populations from which I sampled participants were: all TSs enrolled at one of the four participating tertiary institutions in Gauteng who experienced an UP and/or TOP; and SPs (volunteer counsellors, healthcare professionals, social workers, and psychologists) rendering support services to TSs presenting with UPs and/or TOPs at these tertiary institutions in Gauteng. I came to the conclusion that my decision to remain within the geographical boundaries

originally set for my study was a wise decision, as it was achievable to conduct the research within these confines given the financial resources to my avail and from a logistical point of view, as I work and reside in Gauteng (Pretoria) and was thus able to conduct the fieldwork myself. I furthermore remained with the criteria of inclusion initially formulated for this study (see Section 2.5.1) and I applied purposive sampling, as initially decided on, as strategy for participant recruitment. I also remained with my initial intention of not setting a fixed sample size at the outset of my study, but was guided by the principle of data saturation (Hennink et al., 2011:88; Koerber & Michael, 2008:467).

Having identified the populations and the sampling method for my study, I proceeded with the process of participant recruitment (described in Section 2.5.2 & 3.5.2). The identified populations from the geographically demarcated area resulted in me needing to gain access to multiple sites (namely four tertiary institutions and a CPCC) in Gauteng. Consequently, prior to embarking on my research journey and after I obtained ethical approval and clearance for my study, I made contact with several SPs at various tertiary institutions in Gauteng, as well as volunteer counsellors at the CPCC, with the purpose of gathering information about the prevalence of the topic under investigation; the need for practice guidelines; and the process, protocol and logistics related to, amongst others, gaining access to the different settings and potential research participants. Several of these individuals responded to my request and became gatekeepers who, aside from assisting me with gaining access to the fieldwork sites and potential research participants, were instrumental in identifying and referring potential research participants (namely TSs presenting with an UP and/or TOP, as well as other SPs eligible for participation). Participants were purposively recruited according to the inclusion criteria (see Section 2.5.1) and once their willingness to participate was confirmed, I proceeded with the arrangements for data collection. I prepared the participants for this process by informing them about aspects that would be explored with reference to the research questions and requests that they would have to respond to, and by discussing the ethical considerations that I planned to observe during this research endeavour.

In reflecting on the strategy applied for the recruitment of the participants, I came to the conclusion that it was fitting. I approached settings where I could find potential participants (namely TSs presenting with UPs and/or TOPs, as well as SPs rendering support to these students) and I identified individuals and gatekeepers who could introduce me to potential participants. This strategy enabled me to obtain a sample of information-rich TSs and SPs who have first-hand experience in the issue being investigated and were thus able to provide detailed answers to my research questions (Merriam & Tisdell, 2016:96; Wu et al., 2016:498; Reybold et al., 2012:702-703; Hennink et al., 2011:84).

Prior to engaging the recruited participants in the process of data collection, I undertook a pilot test of the research instruments proposed for the data collection process (namely the interview and discussion guides) in order to identify possible weaknesses in the data collection process and make appropriate adjustments, if needed (Punch, 2016:51; Yin, 2011:37). I also wanted to measure my capability and skill level in terms of conducting qualitative data collection interviews (Wahyuni, 2012:74; Hennink et al., 2011:120; Desai & Potter, 2006:169). The pilot test was conducted with a TS who experienced an UP and chose single parenting as option to manage her UP, as well as one focus group discussion conducted with volunteer counsellors from the participating CPCC. The pilot test led me to conclude that this exercise was a valuable one, as it made me aware of the importance of effective time management during the data collection process. It also made me aware of the importance of the utilisation of summarising skills in order to respond to the participants in an empathic, non-judgemental manner.

The methods of data collection applied with the TS-participants, as described in Chapter Three (see Section 3.5.3), was in-depth, semi-structured, face-to-face interviews and letter writing. After I obtained each student's biographical information, their experiences, support, and support needs related to their experience of the UP and/or TOP, as well as their suggestions for psychosocial support, were explored by means of topic-related requests and questions in the interview guide (cf. Annexure F).

Upon completion of the interview, I extended an invitation to each student to write a letter with the purpose of adding, sharing, or reflecting on any additional information regarding her experience that she either did not think of during the interview or did not feel comfortable to share during the interview. An envelope addressed to me, with writing paper and a postage stamp, was given to each of the TS-participants with the request to post the letter to me within one month of the interview. I envisaged that this additional method of data collection would illuminate the deeper meaning that the participants might attach to their experience (Ritchie & Lewis, 2003:35). It was emphasised, however, that this letter writing was strictly voluntary.

In reflecting on these methods of data collection, I arrived at the conclusion that conducting the in-depth, semi-structured, face-to-face interviews with the TS-participants provided me with an “inside” view of their experiences and support needs related to their UPs and/or TOPs. The participants were also able to freely share their suggestions for psychosocial support. No letters were received from any of the TS-participants, however, and although I perceived this to be a limitation as I expected the letters to provide greater insight into and clarity regarding their UP and/or TOP experience, I was able to conclude that the in-depth responses and information elicited by the interviews provided me with a wealth of useful information (Hennink et al., 2011:109 & 131).

The method of data collection applied with the SP-participants, as described in Chapter Three (see Section 3.5.3), was focus group discussions and semi-structured individual interviews. My initial intention of conducting only focus group discussions with this participant group had to be amended and I had to include the latter as a method of data collection as well, as in some cases only one or two SPs from a specific setting were available to participate in the study. These participants were consequently interviewed individually. This addition to the focus group discussions was permissible, however, given the fact that qualitative research advocates an emerging design (with this aspect referring to the ability to adapt to and/or include new ideas, concepts, or findings that arise while conducting qualitative research and

welcoming unanticipated information as it often adds to the richness of the data) as the research planned cannot necessarily be strictly followed. As the research proceeds, elements of the plan have to be adapted and changed to meet the research field realities (Bruce et al., 2016:2; Frankel & Devers, 2000:253).

After obtaining the biographical information from the participants, their views about the phenomenon of UPs and TOPs amongst TSs were explored, as was their perceptions of the experiences and support needs of TSs in relation to their UPs and/or TOPs. The scopes of the support services offered by the SPs to said students and their suggestions on how these students can be supported were also explored by means of topic-related questions in the discussion/interview guide.

In reflecting on these methods of data collection employed in respect of the SP-participants, I arrived at the conclusion that it was fitting and appropriate, as it enabled them to freely share their views, perceptions, and suggestions, thus providing me with the information that I required in order to answer the research questions. I furthermore concluded that my engagement, as the key instrument in the data collection process (Creswell, 2016:185; Yilmaz, 2013:317), with the TS and SP-participants provided me with an exclusive opportunity to gain insight into and a comprehensive understanding of the experiences, support, and support needs of TSs presenting with an UP and/or TOP.

Consideration of my decision to analyse the data that were collected according to Tesch's eight descriptive steps for qualitative data analysis (Tesch, in Creswell, 2014:198; Tesch, 1990:135) led me to conclude that these steps were well-suited to this endeavour, as it enabled me to administer and analyse the vast amount of data that was obtained in an methodical, logical, and focused manner. Tesch's steps assisted me with extracting word pictures from the data that display the "breadth and scope" of the phenomenon under study (Bless et al., 2013:57). In order to ensure and enhance the trustworthiness of my research findings (Wu et al., 2016:496-497; Bless et al., 2013:236) I furthermore employed the services of an independent coder who

analysed the data sets independently from me. This process assisted with the validation and verification of the data (Yin, 2011:78; Creswell, 2009:202).

The importance of ensuring the accurate representation of qualitative research findings by means of data verification is emphasised by several scholars (Anney, 2014:275; Yin, 2011:20; Denzin & Lincoln, 2005:201; Welman et al., 2005:142). In this regard, I remained with my original intention to establish the trustworthiness of my study by testing the truth value, applicability, consistency, and neutrality against Guba's criteria of credibility, transferability, dependability, and conformability (Guba, in Krefting, 1991:214-222). I applied several strategies, elaborated upon in Chapter Three (see Section 3.5.5) to enhance this study's credibility, transferability, dependability, and conformability and I came to the conclusion that these strategies assisted me to conform to the scientific standards of validity and rigour necessary not only for planning and applying my research project, but also for presenting my research findings.

Lastly, in reflecting on the ethical considerations that were applied in this endeavour, namely obtaining informed consent, avoidance of harm, and the right to privacy, confidentiality of data, and anonymity, I came to the conclusion that the ethical principles applied were fitting and appropriate. I comprehensively informed both my participant groups about the aim of the study; what their participation would entail; that they were to provide me with informed consent; and that participation in the study was completely voluntary. I explained the potential risks and benefits of the study, how I intended to protect their identities, ensure confidentiality and anonymity, and how the information that I collected from them would be managed and shared in a responsible and ethical manner. I furthermore ensured that participation would not result in any harm by having procedures in place for debriefing, should the need therefore arise. I also acknowledged the vulnerability of my participants by endeavouring to ensure that they feel safe and secure at all times, which resulted in them freely and openly sharing their experiences, views, perceptions, and suggestions for psychosocial support.

7.2.4 Summary and conclusions of Chapter Four: Research findings – the experiences, support, and support needs of TSs in relation to their UPs and/or TOPs, as well as their suggestions to inform practice guidelines for psychosocial support

The demographic details of the six TSs who participated in this research study, reported on in Chapter Four (see Section 4.2.1 – 4.2.5), indicated that their ages ranged from 20 to 28 at the time of the occurrence of their UP and/or TOP. In reflecting on the age distribution of the participants, I arrived at the conclusion that, with the exception of one participant who fell in the “young adulthood” category since she was 28 years old when her UP occurred (Lane, 2015:30; Erikson, 1963:245), the participants were found to be in adolescence and/or late adolescence (Isdale et al., 2016; Jordán-Conde et al., 2014:356; Sigelman & Ryder, 2006:305; Santrock, 1998:24), according to Erikson’s psychosocial development life stages model (Dunkel & Harbke, 2017:59; Knight, 2017:1049; Erikson, 1963:245).

The participants were enrolled for different qualifications, such as Information Systems, Law, Human Resources Management, and Education, and were either in their second or third year of study when their UP and/or TOP occurred. In reflecting on the latter aspect, and casting it against the research findings from other studies, I concluded that the findings from this study differ slightly from the findings of some other studies. Naidoo and Kasiram (2006:343) found higher rates of UP amongst first year students and linked it to, amongst other things, ignorance about contraception/pregnancy prevention. The conclusion of several other authors (Naidoo et al., 2013:343; Ibisomi & Odimegwu, 2007:74), namely that “the likelihood of unintended pregnancy increases as the educational level of a young woman increases” (Ibisomi & Odimegwu, 2007:72), seems to ring true for the findings of my study.

In terms of the place of residency, it was indicated that the majority of the TS-participants were utilising university/institutional accommodation during their studies and when their UP and/or TOP occurred. In reflecting on this aspect, I arrived at the

conclusion that, although one would assume that the prevalence of an UP and/or TOP would be higher amongst students making use of private accommodation (as the latter tends to be associated with more freedom and independence, as opposed to institutional accommodation being subject to specific rules and regulations), the place of residence while studying has little or no effect on the occurrence of UPs and/or TOPs.

I furthermore arrived at the conclusion that the participants came from various provinces and indicated the areas where they grew up as semi-urban. Although some scholars describe region as a predictor of sexual and contraceptive behaviour, with the community where a woman comes from playing a role in determining her risk for having an UP or modifying her contraceptive behaviour (Johnson & Madise, 2010:4; Eggleston, in Ibisomi & Odimegwu, 2007:64), it was also found that the variance estimates for urban and rural communities in terms of the risk for UP are not “statistically significant” (Johnson & Madise, 2010:4).

In terms of the language and ethnic distribution of the TS-participants, it was indicated that although English was not their home language, all of the participants, being registered students at an institution of higher education, were fluent in English and comfortable with me conducting the research interview with them in English. The majority of the participants furthermore indicated their race as Black. In reflecting on this finding, I arrived at the conclusion that it corresponds with the findings of several other studies which found higher rates of UPs amongst young Black women (Mbelle et al., 2018:512; Ibisomi & Odimegwu, 2007:67). Although these scholars aver that ethnicity/race as variable could be a predictor of sexual and contraceptive behaviours, I came to the conclusion that the interpretation of such findings should be done with care and where possible, without bias, as the underreporting of the phenomenon of UPs and/or TOPs, as noted by several other authors (‘Lanre, 2010:1960197; Likis, 2009:2; Dahlbäck et al., 2007:665; Sedgh et al., 2007:1338), might play a role in terms of conclusions drawn in this regard.

The remainder of Chapter Four consisted of a presentation of the findings related to the experiences, support, and support needs of the TS-participants in relation to their UPs and/or TOPs, as well as their suggestions to inform the practice guidelines for psychosocial support. This information was presented according to four themes. A brief synopsis of each, accompanied by the conclusions drawn in this regard, will consequently be presented.

- **Theme One: Circumstances leading up to, and the feelings, emotional reactions, and life changes experienced following the UP-experience**

The TS-participants, in response to my question to describe, in as detailed a manner as possible, their situation when they experienced their UP, spontaneously shared information about the nature and length of their relationships prior to the occurrence of the UP, which were perceived and described by three of them as stable, committed, and long-term. One participant described her relationship as “not committed” and two of the participants did not volunteer any information about their relationships.

The reasons offered by the participants for the occurrence of their UPs included lack of contraceptive use, negative attitudes about condom use, and an incorrect risk assessment about falling pregnant (Coetzee & Ngunyulu, 2015; Mchunu et al., 2012:427; Seutlwadi et al., 2012:45-46). In terms of the feelings and emotional reactions experienced by the participants on the confirmation of their UPs, as well as how their lives changed as a result of this incident, they shared that they experienced feelings of shock, denial, disbelief, worry, stress, guilt, shame, loneliness, disappointment, sadness, and anger (Akbarzadeh et al., 2016:190; Barton et al., 2017; Adams & Williams, 2011:1880). Fearing the loss of the relationship with their partners and significant others was also expressed (Tabane & Mmapheko, 2015:2) and, in this regard, some of them indicated that these relationships became strained or came to an end as a result of the UP (Adams & Williams, 2011:1880). It was furthermore indicated that the UP resulted in their financial prospects and academic

progression becoming uncertain and that the UP forced them to grow up and become responsible (Barton et al., 2017; Valois et al., 2013:38; Van Breda, 2011:4).

The findings presented under Theme One resulted in me concluding the following:

- Although it has been found that the UP-rate amongst young, unmarried women is high (Haffejee et al., 2018:80), UPs also very often occur in stable, long-term relationships (Mbelle et al., 2018:512).
 - Despite the availability of resources and young women's seeming ability to negotiate safe sex, ambivalent attitudes, ignorance, and carelessness, specifically with regard to contraceptives, still seem to be very prevalent, significantly increasing the risk of an UP (Bruckner et al., 2004:249).
 - The TS-participants experienced their UP as a crisis, which impacted negatively on their academic, social, relational, and family life (Barton et al., 2017; Tabane & Mmapheko, 2015:1; Daley, 2012:39).
- **Theme Two: Participants' accounts of the decisions taken to deal with the UP, what informed their decisions, and the feelings and emotional reactions experienced afterwards**

The focus in this theme was on the outcome of the UP, namely the decision taken by each of the participants to manage her UP, the factors that influenced the decision taken, and the feelings and reactions following the decision. Four of the TSs indicated that they decided to continue with their UPs and they chose single parenting as option to manage the UP. Their spiritual/Christian beliefs; the advice received from a counsellor that was consulted; having the support of their significant others; and their partner's advice/request to not terminate the UP were factors pointed out by them as influential in this decision (Frederico et al., 2018:34; Rosen, 2010:23). Positive feelings following this decision were expressed by all four the participants (Kjelsvik & Gjengedal, 2011:173).

Two of the participants indicated that they decided to terminate their UPs and they shared that pressure from their significant others to do so; an intense fear of disappointing their significant others, or being stigmatised or shunned by them;

financial worry; and concern about their studies (that their academic goals might be derailed as a result of the UP) were aspects influencing their decision to terminate their UPs (Frederico et al., 2018:329; Miller, 2011:69). One of the participants furthermore confessed that she was not ready for motherhood and that her worry about how the UP would change the course and direction of her life influenced her to opt for a TOP (Steck, 2011:18). The feelings and emotional reactions expressed by the participants who chose TOP to manage their UPs were overwhelmingly negative, in sharp contrast to the participants who decided to continue with their pregnancies, and were characterised by sadness, grief, regret, anger, guilt, shame, and loneliness (Kjelsvik & Gjengedal, 2011:173; Steck, 2011:17; Ekstrand et al., 2009:177).

In reflecting on the decisions taken by the participants to manage their UPs, the factors that influenced their decisions and the feelings and emotional reactions that they experienced as a result of the decision taken, I arrived at the following conclusions:

- An unmarried student facing an UP finds herself in the midst of a crisis for which she has to find a solution as soon as possible. This decision-making process is a difficult one, which might be regretted later in life (Hall et al., 2017:1337; Adams & Williams, 2011:1881).
- Support, or the lack thereof, from significant others plays an important role in the decision-making process (Frederico et al., 2018:34)
- For the TS confronted with an UP, TOP often seems to be a “quick fix” to her problem as it enables the student to continue with her life and studies (Frederico et al., 2018:329; Miller, 2011:69).
- Although some women may experience a sense of relief upon terminating an UP (Kjelsvik & Gjengedal, 2011:174), for the TS-participants who chose this option, the decision to terminate their UP was a difficult one characterised by severe emotional turmoil and trauma (Frederico et al., 2018:337; Kjelsvik & Gjengedal, 2011:1730).
- Adoption as an option to manage the UP was not considered by the participants in this study. Although this seems to be consistent with research findings

confirming that this option is seldom considered (Berglas et al., 2018:386; Pugh, E, 2010:15), further research in this regard to explore the reasons why this option is often met with resistance (Berglas et al., 2018:386; Badenhorst, 2005:980) is recommended.

- **Theme Three: Participants' accounts of the nature of the support received in relation to their UPs and/or TOPs, how they experienced this support, and how they would have liked to be supported otherwise**

From the TS-participants' accounts on the nature of the support received with the UP and/or TOP, I came to the conclusion that they enlisted professional and informal support, both on and off-campus, for counselling and medical support (Kaur, 2016:127; Van Breda, 2011:24). In addition, support was sought and received from their friends, family, and partners (Rahman et al., 2017:70; Kjelsvik & Gjengedal, 2011:172; Van Breda, 2011:24). One participant indicated that she received support from one of her lecturers (Van Breda, 2011:24).

I learnt that for five of the participants the support sought and received was positively experienced. One of the participants (who opted for a TOP) experienced the lack of support from her significant others, together with their pressure to terminate her UP, as extremely negative (Grey, 2015:737; Van Breda, 2011:24).

My request to the students to look back on the support that they received and share with me what they would have liked to be different in terms thereof resulted in the participants sharing that they would have liked to have more –

- information about the on and off-campus support services available to TSs presenting with an UP and/or TOP (Grey, 2014:1196; Rosen, 2010:17-18);
- support from their significant others (Didaba et al., 2013:136; Kjelsvik & Gjengedal, 2011:173); and
- information about the different options to choose from when dealing with an UP and/or TOP (French et al., 2017:716; Hornberger, 2017:2).

One of the participants indicated that she would have liked to be less afraid of what she believed others were saying or thinking about the ordeal of her UP (Smith et al., 2016:76). The participants who chose TOP as option to manage their UP indicated that they would have liked to be better prepared for the TOP-process and procedure (French et al., 2017:217; Hornberger, 2017:3).

After reflecting on the findings presented under this theme, I concluded that reaching out for help and receiving support when confronted with the reality of an UP and/or TOP is of paramount importance, as it assists with making an informed decision on how to handle this crisis, and assists with coping after the decision is taken. Having support furthermore mitigates the challenges associated with an UP and/or TOP; it could serve as a shield to prevent future UPs and/or TOPs and it promotes general wellbeing and resilience (Kjelsvik & Gjengedal, 2011:173; Van Breda, 2011:7).

- **Theme Four: Suggestions for psychosocial support to TSs presenting with an UP and/or TOP**

My request to each of the participants to, based on her experience as a TS who had an UP and/or TOP, offer suggestions on how students who present with this phenomenon could/should be supported resulted in them forwarding suggestions for medical and counselling support; peer support and education; awareness campaigns; and academic related support. They also offered suggestions in terms of how such support could/should be utilised.

In terms of medical support, the participants suggested that the on-campus medical support should be expanded to include services such as pre-natal care, emergency care, check-ups during and after pregnancy, and increased family planning services/contraceptive options. The participants furthermore emphasised the importance of healthcare professionals being more service-oriented, patient-friendly, and supportive (French et al., 2017:716; Kjelsvik & Gjengedal, 2011:173; Levi et al., 2009:310).

With reference to counselling support, the suggestion was to expand the service country-wide and include telephone crisis counselling. Concerning the focus of the counselling support, it should be on counselling regarding UP-options, post-abortion counselling, and relationship/partner counselling (Smith et al., 2017:82; Stewart et al., 2016:62; Kjelsvik & Gjengedal, 2011:172).

The suggestions for peer support and education offered by the participants are endorsed and supported by several scholars who emphasise the value and role thereof in terms of dealing with the difficulties and challenges, such as academic pressure, experienced as a result of an UP and/or TOP (Brittain et al., 2015:76; Van Breda, 2011:25-26; Wilks & Spivey, 2010:281).

Aside from offering suggestions for peer support and education, the participants proposed the increased utilisation of awareness campaigns, not only for the purpose of providing information about UP and TOP, its consequences, and how to prevent it, but also to provide information on available resources and support services to turn to when an UP occurs (Svanemyr et al., 2015:8; Patel & Kooverjee, 2009:560).

Lastly, the participants' suggestions related to academic support included a recommendation that tertiary institutions should amend their rules or policies to not expel students from the university residences when they present with an UP. It was suggested that lecturers should be more involved, as they could provide valuable academic support and assistance, and that pregnant students should be assisted to meet their academic demands and continue with their studies (Van Breda, 2011:20; Burgen, 2010:29).

In reflecting on the suggestions offered by the TS-participants, I arrived at the following conclusions:

- Negative appraisal and attitudes, specifically from healthcare professionals, result in the non-utilisation of resources and support services (Rahman et al., 2017:70) and should be addressed.

- Counselling support, inclusive of the suggestions offered by the participants, has a positive outcome in terms of assisting with the decision-making process, as well as the management of the medical and psychological challenges associated with the experience of an UP and/or TOP (Kilander et al., 2018:105; Van Breda, 2011:6; Burgen, 2010:24).
- Peer-facilitated support and education can mitigate the challenges experienced as a result of an UP and/or TOP and it could assist students with pursuing and achieving their academic goals (Brittain et al., 2015:76; Adams & Williams, 2011:1884; Baird & Porter, 2011:153).
- Increased utilisation of awareness campaigns could result in a decrease in the phenomenon of UPs and/or TOPs and an increase in the utilisation of resources and support services, and should ultimately benefit the student in the attainment of her educational goals (Van Breda, 2011:26; Brosh et al., 2007:575).
- As lack of or negative lecturer interactions, limited or no faculty support, and actual or perceived rigidity by some academic staff regarding aspects such as class attendance, have been found to impact negatively on the educational attainment of the student confronted with an UP and/or TOP (Mbelle et al., 2018:515; Pugh, E, 2010:13), support from academic staff should be enlisted.

I furthermore concluded that the suggestions offered by the TSs are relevant for inclusion in the practice guidelines and that it would be helpful in assisting SPs in their service delivery to TSs presenting with an UP and/or TOP.

The accounts of the TSs on their experiences, support, and support needs in relation to their UPs and/or TOPs, as well as their suggestions to inform practice guidelines for psychosocial support, presented under four themes (which unfolded in several sub-themes and categories) in this chapter, contributed to the realisation of the first goal (pertaining to the TSs) that was formulated for this research endeavour. It furthermore contributed to the body of knowledge on the topic of UPs and TOPs amongst TSs and the provision of psychosocial support to said students.

7.2.5 Summary and conclusions of Chapter Five: Research findings – SPs' perceptions of the experiences and support needs of TS presenting with UPs and TOPs, the scopes of support services offered by them, and suggestions informing practice guidelines for psychosocial support

The demographic details of the 23 SPs who participated in this study were introduced at the outset of this Chapter. Thirteen of the 23 SPs were from the four participating tertiary institutions, with their ages ranging from 25 to 62 years of age. Twelve of them were female. I concluded that this gender distribution is quite common in the field of social work, psychology, and nursing (Ivanovic et al., 2015:338; Pease, 2011:406-407), as these professions tend to be viewed as “female professions” (Pease, 2011:407) because of their nurturing and caretaking functions, viewed by many as “women’s activities” (Pease, 2011:407; Lovelock et al., 2004:73).

The 10 volunteer counsellors from the participating CPCC were female and their ages ranged from 33 to 64 years of age. The ages of six of the participating volunteer counsellors were between 40 to 59 years, which led me to conclude that this corroborates the finding of Rek and Dinger (2016:438) who, in their exploration of the interpersonal characteristics of volunteer counsellors, found that volunteers predominantly tend to be female and that the average age of a volunteer is 52.

Concerning the highest educational qualification of the SPs from the participating tertiary institutions, it was indicated that 12 of them were in possession of a post-graduate qualification. Nine of them furthermore had more than five years’ experience in rendering support services to TSs presenting with UPs and/or TOPs in the field of higher education. In terms of the highest educational qualification of the volunteer counsellors from the participating CPCC, it was indicated that eight of them were in possession of a post-matric/tertiary qualification. All of them indicated that they had a minimum of two years’ experience as volunteer counsellors, with five of the volunteers having six to 10 years’ experience in the field of crisis pregnancy and/or post-abortion counselling. The specialist knowledge, experience, and academic

qualifications of all the SP-participants led me to conclude that it added to the value and credibility of the findings of this research endeavour.

The remainder of Chapter Five comprised of a presentation of the findings related to the SPs' perceptions of the experiences and support needs of TSs presenting with UPs and/or TOPs, the scopes of support services offered to them, and their suggestions to inform the practice guidelines for psychosocial support. These findings were presented under five themes and one unique theme. A brief synopsis of each, accompanied by the conclusions drawn in this regard, will consequently be presented.

- **Theme One: SPs' perceptions about the prevalence, impact, and reasons for the occurrence of UP and/or TOP amongst TSs**

The participants' feedback in this regard indicated that they viewed UPs and TOPs amongst TSs to be a quite widespread and problematically prevalent (Bongaarts & Casterline, 2013:154; Thomas, 2012:2; Yunos, 2010:2). They elaborated extensively upon the impact of this phenomenon on the academic and personal wellbeing of the students, emphasising that the occurrence thereof not only has the potential to disrupt the life of the student, but that it is an extremely challenging and traumatic event for most students (Moore et al., 2017:108; Wise et al., 2017:9; Kjelsvik & Gjengedal, 2011:171; Van Breda, 2011:4). The reasons offered by the SPs for the occurrence of UPs included their perception that it is the result of students' engagement in high-risk sexual behaviour (Mchunu et al., 2012:427; Seutlwadi et al., 2012: 46); negative attitudes and ignorance towards contraception (Coetzee & Ngunyulu, 2015; Mchunu et al., 2012:427); peer pressure (Yunos, 2010:42); and a lack of knowledge and information about sexual and reproductive health (Coetzee & Ngunyulu, 2015; Mchunu et al., 2012:427). Their perceptions of the reasons for the high TOP-rates amongst TSs (Mphatswe et al., 2016:155; Pestvenidse et al., 2016:87) included references to academic, financial, parental, and partner pressure, as well as lack of information on the different options on how to manage an UP (Macleod et al., 2016:1101; Grey, 2015:38; Mavis et al., 2015:1155; Ralph et al., 2014:430).

In reflecting on the findings presented under this theme, I arrived at the conclusion that the views and perceptions shared by the participating SPs in this regard corroborates the experiences shared by the TS-participants, as well the reasons offered by them for the occurrence of this phenomenon. I also became aware of the importance of providing students with knowledge and information about sexual health and reproduction, available resources and support services, and the different options on how to manage an UP.

- **Theme Two: SPs' perceptions on the experiences and support needs of TSs presenting with UPs and/or TOPs**

The feedback from the participants in this regard were indicative of their perception that TSs presenting with an UP and/or TOP experience –

- pressure and confusion about the UP and the management thereof (Hall et al., 2017:1337; Nelson & O'Brien, 2012:507);
- feelings of loneliness and lack of support (Barton et al., 2017; Tabane & Mmapheko, 2015:2);
- fear of the negative reactions of and abandonment by their significant others (Akbarzadeh et al., 2016:191; Tabane & Mmapheko, 2015:2);
- feelings of guilt and shame (Akbarzadeh et al., 2016:191; Adams & Williams, 2011:1879; Kjelsvik & Gjengedal, 2011:172);
- shock, especially upon the confirmation of the UP (Akbarzadeh et al., 2016:190; Adams & Williams, 2011:1880);
- trauma, as a result of the TOP-procedure (Frederico et al., 2018:335; Steck, 2011:16); and
- academic and financial pressure and stress (Barton et al., 2017; Valois et al., 2013:38; Van Breda, 2011:4).

In terms of the support needs of this client system group, it was indicated that the SPs perceive TSs presenting with an UP and/or TOP to be in need of counselling support, on-campus medical support, as well as academic support (French et al., 2017:716; Adams & Williams, 2011:1881; Kjelsvik & Gjengedal, 2011:1172; Van Breda, 2011:24).

Based on the shared perceptions of the SPs, I arrived at the conclusion that that the experience of an UP and/or TOP for many, if not all TSs, is a stressful and traumatic life challenge, especially given its psychological, social, educational, economic, and medical consequences (Mantell et al., 2015:1133; Van Breda, 2011:3; 'Lanre, 2010:197). The feelings, emotional reactions, and support the SPs perceived these students to have corroborate what the TS-participants shared in this regard. An UP and/or TOP has the potential to derail the life of the student, influencing her ability to cope with severe and compelling academic demands. This underscores the need for psychosocial support to ensure a calculated and informed decision on how to manage the UP and to enhance the student's psychosocial wellbeing (Kjelsvik & Gjengedal, 2011:172; Miller, 2011:69). The increased utilisation of resources and support services (French et al., 2017:716; Baird & Porter, 2011:156) will mean the difference between academic failure or success (Mbelle et al., 2018:515; Burgen, 2010:29).

- **Theme Three: The scopes of the support service offered by SPs to TSs presenting with an UP and/or TOP**

From the responses of the SPs in elaborating on the scopes of the support services that they offer to TSs presenting with an UP and/or TOP, I learnt that they offer the following services:

- crisis pregnancy counselling (Kjelsvik & Gjengedal, 2011:174; Van Breda, 2011:21);
- post-abortion and bereavement counselling (Rose et al., 2011:1734; Burgen, 2010:24; Martin & Oswin, 2010:59);
- referral to and liaison with internal and external resources and the TS's significant others (Kjelsvik & Gjengedal, 2011:172; Van Breda, 2011:20);
- life skills and psycho-education (Haaberland & Rogow, 2015:18; Yankey & Biswas, 2012:514); and
- medical support (Van Breda, 2011:26; Rosen, 2010:17).

I concluded that the above-mentioned support offered by the SPs also provides an opportunity to explore and address additional aspects such as high-risk sexual behaviour, healthy sexuality, relationship issues, the promotion of contraception and abstinence in an attempt to address the prevalence of and increase in UPs and TOPs, financial management, and academic challenges.

- **Theme Four: SPs' accounts of the resources available and obstacles encountered in rendering support services to TSs presenting with UPs and/or TOPs**

When I asked the SPs to tell me about the scopes of the support services that they offer, elaborated upon in the previous theme, they spontaneously elaborated on their perceptions of the resources available to assist them in their service delivery, as well as the obstacles that hinder them in their service delivery to TSs presenting with an UP and/or TOP. In listing the resources, they elaborated on the value of the following: peer/collegial support (Collins et al., 2010:973; O'Connor & Cordova, 2010:364; Zastrow, 2010:197); specialised and on-going training (Wiebe et al., 2014:226; Baird & Porter, 2011:156; Van Breda, 2011:26); their physical location and having private offices available (this resource was specifically mentioned by the volunteer counsellors from the participating CPCC) (Baird & Porter, 2011:156; Bafana, 2010:10); and having the option available to refer students and having resources to refer to. In terms of aspects perceived by them as obstacles, the following were listed: lack of finances; staff shortages; language and cultural barriers; the location and distance between student service departments at the tertiary institutions (Miller, 2011:71; Levi et al., 2009:311); TSs' non-utilisation of available resources (Van Breda, 2011:24; Rosen, 2010:18); tertiary institutions' residential policies with regard to student pregnancy (Van Breda, 2011:5, Martin & Oswin, 2010:57); and the perceived permissiveness of the CTOP Act 92 of 1996 (South Africa, 1996) (Thomas, 2012:3; Yunos, 2010:4).

In reflecting on the above-mentioned accounts of the SPs, I became aware of the importance of acknowledging and addressing the challenges that they might be

experiencing or exposed to as a result of their service delivery. Dealing with the distress experienced by TSs experiencing an UP and/or TOP could result in the SP feeling overwhelmed or vulnerable. I consequently arrived at the conclusion that the provision of psychosocial support to TSs presenting with UPs and/or TOPs should, amongst others, be based on and characterised by the resources available, as expressed by the SP-participants.

- **Theme Five: SPs' suggestions for informing practice guidelines for psychosocial support to TSs presenting with an UP and/or TOP**

The SPs' suggestions in terms of the practice guidelines for psychosocial support focused on the "how to" or the format in which the psychosocial support should be offered, as well as the content that should be covered. They suggested that the psychosocial support to TSs presenting with an UP and/or TOP should be offered through individual counselling, group work, and community outreaches. It should be directed at both female and male students and should address the following aspects/topics: crisis pregnancy counselling; pre- and post-abortion counselling; information on UP-options, relationships, and sexual and reproductive health; contraception/preventative measures; financial management; and information on the availability of resources and support services. Emphasis was placed on effective strategies to market the latter (Baird & Porter, 2011:153; Kjelsvik & Gjengedal, 2011:172; Van Breda, 2011:20; Corkin, 2011:4; Rosen, 2010:16).

Additional suggestions regarding the prerequisites related to the implementation of the practice guidelines were also offered. In this regard the SP-participants proposed that psychosocial support to students should be enhanced through better networking, cooperation, and referrals between tertiary institutions, significant others, and community resources (Kjelsvik & Gjengedal, 2011:174; Van Breda, 2011:21; Martin & Oswin, 2010:59; Wilks & Spivey, 2010:281). They furthermore felt quite strongly about the practice guidelines being user-friendly, holistic, flexible, and available to all relevant role players (Adams & Williams, 2011:1877; Baird & Porter, 2011:155; Van

der Westhuizen, 2010:209; Levi et al., 2009:309) and that the guidelines should inform tertiary institutions' policies related to student pregnancy.

In reflecting on the suggestions offered by the SP-participants, I concluded that some of the topical suggestions had a strong preventative, life skill, and life orientation focus and that they aimed to include the student population as a whole, not only female students. I furthermore concluded that the suggestions are relevant for inclusion in the practice guidelines and that they would be helpful in assisting SPs in their service delivery to TSs presenting with UPs and/or TOPs.

- **Unique theme: SPs rendering support services to TSs presenting with an UP and/or TOP should receive specialised and on-going training (specifically related to the phenomenon)**

This need and the consequent suggestion were offered by the SPs from the participating tertiary institutions. As mentioned earlier, the volunteer counsellors from the participating CPCC shared that the specialised training that they receive in order to provide support to women confronted with an UP and/or TOP was perceived as a resource in their service delivery. I concluded that the accounts from the SPs from the participating tertiary institutions in this regard attest to their acknowledgement that crisis pregnancy and TOP-counselling is a specialised field of service delivery (Baird & Porter, 2011:156; Burgen, 2010:23; Levi et al., 2009:312) requiring specialised, on-going training characterised by adequate, appropriate, tailor-made elements. I thus concluded that this suggestion is functional and directive in view of the practice guidelines, as empowering SPs with specialist knowledge, information, and training, and encouraging continued professional development would assist them in their service delivery to TSs presenting with UPs and/or TOPs.

The accounts of the SP-participants on their perceptions of the experiences and support needs of TSs presenting with UPs and/or TOPs, the scopes of the support services offered by them, and their suggestions to inform practice guidelines for psychosocial support presented under five themes (which unfolded in several sub-

themes and categories) and one unique theme in this chapter, contributed to the realisation of the first and the second goal (pertaining to the SPs) that were formulated for this research endeavour. It furthermore contributed to the body of knowledge on the topic of UPs and TOPs amongst TSs within the context of higher education and the provision of psychosocial support to said students.

7.2.6 Summary and conclusions of Chapter Six – Practice guidelines for psychosocial support to TSs presenting with an UP and/or TOP

The practice guidelines proffered in Chapter Six were based and informed by literature and the empirical findings of this study, namely the experiences, support, and support needs of the TS-participants who presented with an UP and/or a TOP and their suggestions for psychosocial support (reported on in Chapter Four of this thesis), as well as the accounts of the SP-participants who shared their perceptions about the experiences and needs of these students, the scopes of the services offered to these students, and the suggestions forwarded by them for the provision of psychosocial support to TSs presenting with an UP and/or TOP (reported on in Chapter Five of this thesis).

The practice guidelines were furthermore imbedded in the following policy frameworks: the White Paper for Social Welfare (1997); the ISDM for Developmental Social Services (DSD, 2005); and the Framework for Social Welfare Services (DSD, 2013). Aside from these policy frameworks informing the practice guidelines, several other policies and legislation also underpin it, namely: the National AYHP (DoH, 2017); the NAFCI (Ashton et al., 2009); and the CTOP Act No 92 of 1996 (South Africa, 1996).

The goal of the practice guidelines is to provide directives and pointers to SPs on how to establish a helping relationship with a TS presenting with an UP and/or a TOP, and to assess and intervene in the *situation*, the *self*, the *support*, and the (coping) *strategies* surrounding the TS's UP and/or TOP, with these four facets being known

as the 4S-system in Schlossberg's Transition Process Model (Anderson et al., 2012; Schlossberg, 2011; 1981), adopted as theoretical framework for this study (see Section 1.4).

The content of the practice guidelines was structured around several suggestions for establishing a helping relationship with the TS presenting with an UP and/or TOP, with several relationship-building skills being offered. The purpose and function of psychosocial support and the prerequisite knowledge base required by the SP for the provision thereof, with emphasis on the value and importance of forming a collaborative relationship with the student and, amongst others, being aware of the barriers preventing TSs from reaching out for help and support, were also presented.

Practice guidelines on how to address these barriers were also formulated.

Following the establishment of a therapeutic relationship and drafting of a therapeutic contract, an assessment tool (as practice guideline) was suggested for gathering biopsychosocial information about the TS presenting with an UP and/or TOP. Comprehensive assessment is seen as critical in terms of effective service delivery (Rodda et al., 2015:117; DSD, 2005) and the provision of psychosocial support, as it assists the SP in her exploration and appraisal of the TS's circumstances, the TS's inner strength to cope with and her ability to manage her UP or TOP, as well as the resources and support available to assist the TS. Such assessment furthermore ensures the development of an appropriate intervention plan (Rodda et al., 2015:117; DSD, 2005).

In terms of practice guidelines to intervene in the presentation of an UP, the Six-step Model of Crisis Intervention (adopted and adapted from James & Gilliland, 2012) and the Six Steps to Crisis Intervention (adopted and adapted from Philkill and Walsh, 2002) were suggested. This was followed by several practice guideline suggestions with practical functional aids for revisiting the circumstances leading up to and the feelings and emotional reactions following the TS's UP-experience. Practice

guidelines for appraising and enhancing the psychosocial competence of the TS in the decision-making process regarding her UP were presented next, with these being inclusive of functional aids on how to assess the student's self-esteem and her appraisal of the comprising parts of her self-concept. Practice guidelines for encouraging self-reflection in view of enhancing and/or maintaining a positive self-appraisal, as well as suggestions for challenging negative self-talk, were also offered.

In terms of the multiple losses often associated with the experience of an UP, which tends to find expression in the experience of sadness, stress, and depression (Harries et al., 2015:6; Bradshaw & Slade, 2013:934), practice guidelines containing functional aids for assessing the presence of depression and stress, as well as suggestions for the management thereof, were offered. In addition, guidelines for appraising and enhancing the resources and assistance available to assist during the UP and the decision-making process to deal with the UP were offered, with these including suggestions and functional aids for exploring and accessing the interpersonal and institutional sources of support available that could help/hinder the student in the UP-crisis and the decision-making process on how to manage it.

In terms of practice guidelines for reflecting on the decision taken to manage the UP and the outcome thereof (parenting the child, foster care, adoption, or a TOP), several strategies (as practice guidelines) for exploring, assessing, and intervening in this regard were suggested. In an attempt to address the challenges experienced and expressed by the student choosing TOP to manage her UP (elaborated upon extensively in this thesis – See Chapter One, Sub-section 1.1.2 & Chapter Four, Sub-section 4.3.2), Eagle's Integrative Model for Brief Term Intervention in the Treatment of Psychological Trauma (adopted and adapted from Eagle, 1998) and "The Journey: a road to post-abortion recovery" (adopted and adapted from Thompson, 2005) were suggested as practice guidelines for intervention. The purpose of these suggested guidelines was to support and enhance the strategies employed by the TS, also taking cognisance of the fact that the experience of PAS/trauma as a result of the

termination of an UP has been established (Rocca et al., 2015; Bradshaw & Slade, 2013:936; Curley & Johnston, 2013:279).

In reflecting on the practice guidelines for psychosocial support proffered and presented in Chapter Six, I arrived at the conclusion that they contributed to the body of knowledge on the topic of UPs and TOPs amongst TSs within the context of higher education. I also concluded that these guidelines filled the gap in existing psychosocial support to TSs presenting with UPs and/or TOPs. As the guidelines were informed by the accounts of the TSs on their experiences, support, and support needs in relation to their UPs and/or TOPs; the accounts of the SP-participants on their perceptions of the experiences and support needs of TSs presenting with UPs and/or TOPs; and the scopes of the support services offered by them to said students; as well as both groups' suggestions for psychosocial support, I furthermore concluded that it contributed to the realisation of the goal that was formulated for this study in this regard (see Section 2.3).

The practice guidelines for psychosocial support contain many activities and functional aids (such as “how to” and “what to do”) to assist SPs in their service delivery to TSs presenting with UPs and/or TOPs. It was emphasised however that the suggestions offered are flexible, allowing for adaptation and adjustment to suit the unique needs, circumstances, and style of each SP involved in the provision of support to said client system group.

7.3 LIMITATIONS INHERENT IN THIS STUDY

The following limitations inherent in this study are acknowledged:

- **Non-generalisation of the research findings as a limitation.** I applied the qualitative research approach in this endeavour with the purpose of obtaining an in-depth view of the experiences, support, and support needs of TSs presenting with an UP and/or TOP. This approach offers context-bound information, which does not allow for the generalisation of findings to broader contexts.

- **Sample size as a limitation.** Although the qualitative research approach supports the notion of recruiting a small sample of information-rich participants (Rubin & Babbie, 2013:40; Mahthani, 2004:55), the small number of TSs who participated in this study is acknowledged as a limitation.
- **Demographic details of the TS-participants, with reference to ethnicity, as a limitation.** The majority of the TSs who participated in this study were Black. The lack of Indian and White participants, despite this exclusion not being intentional, is acknowledged as a limitation.

7.4 RECOMMENDATIONS

The following recommendations, informed by my own social work experience in the field of higher education offering psychosocial support to TSs presenting with UPs and/or TOPs, the literature, and the empirical findings of this study (presented in Chapter Four and Five), are offered:

- **Recommendation for university policies on student pregnancy**

It is recommended that universities revisit their policies relating to student pregnancy, with specific reference to residence accommodation. As elaborated upon earlier in this research report (see Section 1.2), current rules at most tertiary institutions do not allow pregnant students to reside in institutional accommodation after the fifth month of their pregnancy. This regulation is viewed by many as restrictive (also elaborated upon and confirmed by the research findings of this study – see Section 4.3.4, 5.3.2.2 & 5.3.4.2) and has been found to put pressure on the TS confronted with a crisis pregnancy, often resulting in an impulsive or hurried decision regarding the management of the UP that might be regretted later. It is recommended that universities consider, if the pregnant student's health permits it, allowing the student to reside in university-provided accommodation for as long as possible/the duration of her pregnancy. Should this option not be viable or applicable, liaison with community resources and/or the private sector to establish alternative forms of accommodation

to support the student during her pregnancy and, amongst others, assist with guidance regarding the management of her UP, is recommended. Pregnant students should be encouraged to continue with their studies and appropriate academic, medical, and counselling support should be provided by the tertiary institution in this regard.

- **Recommendations for social work practice**

It is recommended that –

- the findings of this research study, with specific reference to the reasons for the occurrence of UPs and/or TOPs amongst TSs; the feelings and emotional reactions experienced by them as a result thereof; the outcome of their UP-crises (in other words, how they managed the UP); and their needs and suggestions for support, as well as the perceptions of the SPs related to the mentioned aspects, be widely communicated and publicised. This dissemination can be done at institutions of higher education, CPCCs, community clinics, NGOs, and government departments by means of seminars, workshops, information sessions, or publications in scholarly journals, with the purpose of informing SPs of the experiences and support needs of such students.
- the practice guidelines proffered (Chapter Six) be packaged as workshop material (in a booklet or as handouts) and be presented at workshops, seminars, and continuous professional development initiatives amongst social welfare and healthcare professionals, teachers, volunteer counsellors, and telephone crisis counsellors confronted with UPs and/or TOPs amongst adolescents and the youth in order to equip and assist them in their provision of psychosocial support to the girls and women affected by this phenomenon.
- the information and the practice guidelines for psychosocial support that became available through this research endeavour be adopted in the syllabi of modules

at institutions where social workers, psychologists, teachers, and healthcare professionals are trained. This information could be included in modules focusing on child and family welfare, human development, and health and reproductive health.

- **Recommendations regarding the research methodology applied in this study**

Given the flexible and emergent nature of the qualitative research approach, causing especially the novice researcher to experience the qualitative research process as muddled and disorderly, a level of flexibility is recommended. In taking heed of Brown's succinct explanation of the emergent nature of qualitative research (in Lichtman, 2014:40), it is recommended that the researcher be open to change and willing to adjust the research plan as:

...we don't always know until we're well into the project where we are placing our emphasis. Often we change directions and take new tacks in the midst of the work, due to our own realisation about the material, and in part from the ongoing interpretation with people.

It is furthermore recommended that, where fieldwork involves multiple settings and participant groups, the researcher endeavours to identify, establish, and maintain good relationships with gatekeepers, as they are the individuals who assist with the regulation and provision of access to the research sites and participants (Creswell & Poth, 2017:320; Creswell, 2013:231). Utilisation of appropriate networking skills in this regard is also recommended.

As the qualitative research process normally results in the generation of vast amounts of data, it is recommended that the services of an independent coder be enlisted to assist with analysing the data set independently from the researcher. The process of independent coding assists with authenticating and substantiating the research findings, which in turn enhances the trustworthiness of said findings (Yin, 2011:78; Wahyuni, 2012:72; Creswell, 2009:202).

- **Recommendations for further research**

My motivation for embarking on this research journey was sparked by my concern about the prevalence of, increase in, and negative impact of UPs and TOPs on TSs, their significant others, and tertiary institutions. Immersing myself into this topic, I concluded that there was a stillness in the knowledge base within the disciplines of social work, nursing, and psychology, nationally and internationally, in terms of suggestions, strategies, programmes, interventions, and guidelines to support and assist TSs who present with this phenomenon. Based on this conclusion, it is recommended that further research focusing on the provision of support to TSs presenting with UPs and/or TOPs be conducted.

As this research endeavour focused only on a small sample located in a geographically demarcated urban area in only one of South Africa's nine provinces, namely Gauteng, I would like to recommend that this study be replicated in other provinces and at other tertiary institutions. I would also like to further recommend that follow-up studies should attempt to include student participants from other ethnic groups and, as only six TSs participated in this study, that it should be replicated on a larger scale.

It is recommended that research be conducted on SPs' experiences in utilising the practice guidelines for psychosocial support proposed in this study.

An agenda for further research on the following topics is recommended:

- An exploration in the level of preparedness of student counsellors to render support services to TSs presenting with UPs and/or TOPs.
- The development of tailor-made support programmes for TSs presenting with UPs and/or TOPs.
- An exploration into the barriers preventing TSs presenting with UPs and/or TOPs from utilising on- and off-campus resources and support services available to them.

- An investigation into the effect of tertiary institutions' rules, regulations, and policies with regard to how students manage their UPs.

7.5 CHAPTER SUMMARY

The final chapter of this research report provided a summary and conclusion of the following:

- The general introduction and orientation to the study, the research problem, rationale for the study, and the theoretical framework that was adopted for the study.
- The proposed research plan, which consisted of the research questions, research goals and objectives, as well as the proposed methodology for investigating the identified research problem.
- The application of the research methodology with reference to the utilisation of the qualitative research approach, the research designs and methods applied, as well as the strategies applied to ensure the trustworthiness of the findings of the study. The procedures applied to ensure adherence to the ethical considerations deemed relevant to the nature and topic of the study were also addressed.
- The research findings relating to the experiences, support, and support needs of TSs in relation to their UPs and/or TOPs, and their suggestions to inform practice guidelines for psychosocial support.
- The research findings relating to the SPs' perceptions of the experiences and support needs of TSs presenting with UPs and TOPs, the scopes of support services offered by them, and suggestions informing practice guidelines for psychosocial support.
- The practice guidelines for psychosocial support to TSs presenting with an UP and/or TOP.

This chapter was concluded with a reflection on the limitations of the study, after which a recommendation pertaining to tertiary institutions' policies on student

pregnancy was made. This was followed by several recommendations for social work practice; recommendations regarding the research methodology applied in this study; as well as recommendations for further research.

List of References

- 'Lanre, O.O. 2010. Perception of university students on unwanted pregnancy in south west Nigeria. American Journal of Social and Management Sciences, 1(2):196-200.
- Abiodun, O.M. & Balogun, O.R. 2009. Sexual activity and contraceptive use among young female students of tertiary educational institutions in Ilorin, Nigeria. Contraception, 79(2): 146-149.
- Acocella, I. 2012. The focus groups in social research: advantages and disadvantages. Quality and Quantity, 46(4):1125-1136.
- Adams, H.L. & Williams, L.R. 2011. What they wish they would have known: Support for comprehensive sexual education from Mexican American and White adolescents' dating and sexual desires. Children and Youth Services Review, 33(10):1875-1885.
- Adler, N.E., David, H.P., Major, B.N., Roth, S.H., Russo, N.F. & Wyatt, G.E. 1992. Psychological factors in abortion. American Psychologist, 47(10):1194-1204.
- Aiken, A.R.A., Dillaway, L. & Mevs-Korff, N. 2015. A blessing I can't afford: Factors underlying the paradox of happiness about unintended pregnancy. Social Science & Medicine, 132(5):149-155.
- Akbarzadeh, M., Yazdanpanahi, Z., Zarshenas, L. & Sharif, F. 2016. The Women's Perceptions About Unwanted Pregnancy: A Qualitative Study in Iran. Global Journal of Health Science, 8(5):189–196.
- Akintade, O.L., Pengpid, S. & Peltzer, K. 2011. Awareness and use of and barriers to family planning services among female university students in Lesotho. South African Journal of Obstetrics and Gynaecology, 17(3):72-78.
- Akintola, O. 2010. Perceptions of rewards among volunteer caregivers of people living with AIDS working in faith-based organizations in South Africa: a qualitative study. Journal of the International AIDS Society, 13(22):1-10.
- Allan, G. & Moffett, J. 2016. Professionalism in career guidance and counselling – how professional do trainee career practitioners feel at the end of a postgraduate programme of study? British Journal of Guidance & Counselling, 44(4):447-465.

- Alpaslan, A.H. 2018. Reframing the death of the marital relationship as an opportunity for growth: A programme for facilitating post-divorce adjustment. Social Work/Maatskaplike Werk, 54(3):308-326.
- Alpaslan, N. 1997. Methods and means for a meaningful marriage. A preparation for marriage and marriage guidance workbook. Pretoria: Kagiso Publishers.
- Alston, M. & Bowles, W. 2003. Research for social workers. 2nd Edition. London: Routledge.
- Amankwaa, L. 2016. Creating protocols for trustworthiness in qualitative research. Journal of Cultural Diversity, 23(30):121-127.
- Anderson, D.M. 2002. Mosby's Medical, Nursing and Allied Health Dictionary. 6th Edition. Sv "pregnancy". St. Louis, MO: Mosby.
- Anderson, M.L., Goodman, J. & Schlossberg, N.K. 2012. Counselling Adults in Transition. Linking Schlossberg's Theory with Practice in a Diverse World. 4th Edition. New York, NY: Springer Publishing Company.
- Anney, V.N. 2014. Ensuring the quality of the findings of qualitative research. Journal of Emerging Trends in Educational Research and Policy Studies, 5(2):272-281.
- Arhin, A.O. & Cormier, E. 2008. Factors influencing decision-making regarding contraception and pregnancy among nursing students. Nurse Education Today, 28:210-217.
- Ashton, J., Dickson, K. & Pleaner, M. 2009. Evolution of the National Adolescent-Friendly Clinic Initiative in South Africa. [Online]. Available: http://apps.who.int/iris/bitstream/handle/10665/44154/9789241598361_eng.pdf;jsessionid=97439E1518D8384082354E7182001DB6?sequence=1 [Accessed: 06/02/2014].
- Aujoulat, I., Libion, F., Berrewaerts, J. & Noirhomme-Renard, F. 2010. Adolescent mothers' perspectives regarding their own psychosocial and health needs: A qualitative exploratory study in Belgium. Patient Education and Counseling, 81(3):448-453.
- Babbie, E. & Mouton, J. 2007. The Practice of Social Research. Cape Town: Oxford University Press.
- Babbie, E. & Mouton, J. 2010. The Practice of Social Research. 12th Edition. Cape Town: Oxford University Press.

- Babbie, E. 2007. The Practice of Social Research. 11th Edition. Belmont, CA: Thomson Wadsworth.
- Babbie, E. 2010. The Practice of Social Research. 12th Edition. Belmont, CA: Thomson Wadsworth.
- Babbie, E. 2014. The Basics of Social Research. 6th Edition. Mexico: Wadsworth.
- Badenhorst, G., Van Staden, A. & Coetzee, E. 2008. Trends in sexual behaviour among Free State University students. The Social Work Practitioner-Researcher, 20(1):106-122.
- Badenhorst, R. 2005. Reasons for women to terminate a pregnancy: a qualitative study. Unpublished dissertation. Pretoria, University of Pretoria.
- Bafana, T. 2010. Factors influencing contraceptive use and unplanned pregnancy in a South African population. Unpublished dissertation. Johannesburg, University of the Witwatersrand.
- Baird, A.S. & Porter, C.C. 2011. Teenage Pregnancy: strategies for prevention. Obstetrics, Gynaecology and Reproductive Medicine, 21(6):151-157.
- Balaluka, G.B., Nabugobe, P.S., Mitangala, P.N., Cobohwa, N.B., Schirvel, C., Dramaix, M.W. & Donnen, P. 2012. Community volunteers can improve breastfeeding among children under six months of age in the Democratic Republic of Congo crisis. International Breastfeeding Journal, 7(2). [Online]. Available: <https://internationalbreastfeedingjournal.biomedcentral.com/articles/10.1186/1746-4358-7-2>. [Accessed: 14/06/2016].
- Bankole, A., Ahmed, F.H., Neema, S., Quedraogo, C. & Konyani, S. 2007. Knowledge of correct condom use and consistency of use among adolescents in four countries in Sub-Saharan Africa. African Journal of Reproductive Health, 11:198-220.
- Bankole, A., Singh, S., Hussain, R & Oestreicher, G. 2009. Condom use for preventing STI/HIV and unintended pregnancy among young men in Sub-Saharan Africa. American Journal of Men's Health, 3(1):60-78.
- Barber, J.S., Kusunoki, Y., Gatny, H. & Yarger, J. 2010. Relationship characteristics predicting unintended pregnancies reported in an online weekly survey: Preliminary results. [Online]. Available: <https://www.psc.isr.umich.edu/pubs/pdf/rr10-702.pdf> [Accessed: 14/08/2017].

- Barbour, S.A. 2000. The role of qualitative research in broadening the 'evidence base' for clinical practice. Journal of Evaluation in Clinical Practice, 6(2):156-163.
- Barton, K., Redshaw, M., Quigley, M.A. & Carson, C. 2017. Unplanned pregnancy and subsequent psychological distress in partnered women: a cross-sectional study of the role of relationship quality and wider social support. BMC Pregnancy and Childbirth, 17(44). [Online]. Available: <http://doi.org/10.1186/s12884-017-1223-x> [Accessed: 14/08/2017]
- Bearinger, L.H., Sieving, R.E., Ferguson, J. & Sharma, V. 2007. Global perspectives on the sexual and reproductive health of adolescents: patterns, prevention and potential. The Lancet, 369(9568):1220 – 1231.
- Beekman, L. & Scholtemeyer, A. 2012. Counselling students in open and distance learning. In: Beekman, L., Cilliers, C. & De Jager, A. Student counselling and development. Contemporary issues in the South African context. Pretoria: UNISA Press: 257-269.
- Bello, B., Kielowski, D., Heederik, D. & Wilson, K. 2010. Time-to-pregnancy and pregnancy outcomes in a South African population. BMC Public Health, 10(565):1-8.
- Benokraitis, N.V. 2005. Marriages and Families: changes, choices and constraints. New Jersey: Prentice Hall.
- Berge, J.M., MacLehose, R., Eisenberg, M.E., Laska, M.N. & Neumark-Sztainer, D. 2012. How significant is the 'significant other'? Associations between significant others' health behaviors and attitudes and young adults' health outcomes. The international journal of behavioral nutrition and physical activity, 9(35):1-8. [Online]. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3410807> [Accessed: 01/12/2017].
- Berglas, N., Brindis, C.D. & Cohen, J. 2003. Adolescent Pregnancy and Childbearing in California. [Online]. Available: https://www.researchgate.net/publication/239927656_Adolescent_Pregnancy_and_Childbearing_in_California [Accessed: 09/02/2014].
- Berglas, N.F., Williams, V., Mark, K. & Roberts, S.C.M. 2018. Should prenatal care providers offer pregnancy options counseling? BMC Pregnancy and Childbirth, 18:384-391.

- Berman, S.M., Strauss, S. & Verhage, N. 2000. Treating Mental Illness in students: A New Strategy. Chronicle of Higher Education, 46(41):1-9.
- Bezuidenhout, J.F. 2004. A reader on selected social issues. 3rd Edition. Pretoria: Van Schaik.
- Bhorat, H., Lilenstein, K., Magadla, S. & Steenkamp, F. 2015. Youth Transitions From Schooling to the Labour Market in South Africa: Characteristics, Determinants and Solutions. Unpublished concept note.
- Bhuda, G.B. 2008. Abortion and Contraceptives: An exploratory Study. Unpublished MA dissertation. Pretoria, University of Pretoria.
- Biggs, M.A., Upadhyay, U.D., Steinberg, J.R. & Foster, D.G. 2014. Does abortion reduce self-esteem and life satisfaction? Quality of life research: an international journal of quality of life aspects of treatment, care and rehabilitation, 23(9):2505-2513.
- Blanchard, K., Lince-Deroche, N., Feters, T., Devjee, J., De Mendes, I.D., Trueman, K., Sudhinaraset, M., Nkonko, E. & Moodley, J. 2015. Introducing medication abortion into public sector facilities in KwaZulu-Natal, South Africa: An operations research study. Contraception, 92:330-338.
- Bledsoe, S.M., Jordan, H.G., West, B.S. & Reed, E. 2016. Evaluation of Mas (Maximizing Health Care Provider Performance): Supporting Health Care Providers to increase access to abortion care and post abortion contraception provision in Kenya and South Africa. Contraception, 94(4):387-430.
- Bless, C., Higson-Smith, C. & Kagee, A. 2006. Fundamentals of social research methods – an African perspective. 4th Edition. Cape Town: Paarl Printers.
- Bless, C., Higson-Smith, C. & Kagee, A. 2011. Fundamentals of social research methods – an African perspective. Cape Town: Juta.
- Bless, C., Higson-Smith, C. & Sithole, S.L. 2013. Fundamentals of social research methods. Cape Town: Juta.
- Bongaarts, J. & Casterline, J. 2013. Fertility Transition: Is sub-Saharan Africa Different? Population and Development Review, 38:153-168.
- Botha, P. 2014. A life coaching programme for the support of social work students within an open and distance learning context. DPhil Social Work dissertation. Pretoria, University of South Africa.

- Bouchard, G. 2005. Adult couples facing a planned or an unplanned pregnancy: Two realities. Journal of Family Issues, 26:619-637.
- Bowen, G.A. 2009. Supporting a grounded theory with an audit trail: an illustration. International Journal of Social Research Methodology, 12(4):305-316.
- Bowes, T. & Macleod, C. 2006. The characteristics of women seeking termination of pregnancy at an urban-based government hospital in the Eastern Cape. Curationis, 29(4):12-16.
- Bradshaw, Z. & Slade, P. 2013. The effects of induced abortion on emotional experiences and relationships: A critical review of the literature. Clinical Psychology Review, 23(7):929-958.
- Brittain, A.W., Williams, J.R., Zapata, L.B., Pazol, K., Romero, L.M. & Weik, T.S. 2015. Youth-friendly family planning services for young people: A systematic review. American Journal of Preventative Medicine, 49(2):73-84.
- Brosh, J., Weigel, D. & Evans, W. 2007. Pregnant and parenting adolescents' perception of sources and supports in relation to educational goals. Child Adolescent Social Work Journal, 24(6):565-578.
- Brosh, J., Weigel, D. & Evans, W. 2009. Assessing the supports needed to help pregnant and parenting teens reach their educational and career goals. Journal of Extension, 47(1):1-6. [Online]. Available: <http://www.joe.org/2009february/rb8.php> [Accessed: 12/09/2013].
- Bruce, A., Beuthin, R., Sheilds, L., Molzahn, A. & Schick-Makaroff, K. 2016. Narrative research evolving: evolving through narrative research. International Journal of Qualitative Methods, January-December:1-6.
- Bruckner, H., Martin, A. & Bearman, P.S. 2004. Ambivalence and pregnancy: Adolescents attitudes, contraceptive use and pregnancy. Perspectives on Sexual and Reproductive Health, 36:248-257.
- Burckett, K.W. & Morris, E.J. 2015. Enabling trust in qualitative research with culturally diverse participants. Journal of Pediatric Health Care, 29:108-112.
- Burgen, B. 2010. Women with Cognitive Impairment and Unplanned or Unwanted Pregnancy: A 2-year Audit of Women Contacting the Pregnancy Advisory Service. Australian Social Work, 63(1):18-34.

- Bury, L., Hoggart, L. & Newton, V.C. 2015. Young women's experiences of unintended pregnancy and abortion: key findings. [Online]. Available: http://oro.open.ac.uk/45138/1/MSI_key-findings_10-15_email.pdf [Accessed: 17/06/2017].
- Busetto, L., Luijckx, K., Calciolari, S., González-Ortiz, L.G. & Vrijhoef, H.J.M. 2017. The development, description and appraisal of an emergent multimethod research design to study workforce changes in integrated care interventions. International Journal of Integrated Care, 17(1):1-11.
- Calvert, C., Baisley, K., Doyle, A.M., Maganja, K., Chagalucha, J., Watson-Jones, D., Hayes, R.J. & Ross, D.A. 2013. Risk factors for unplanned pregnancy among young women in Tanzania. Journal of Family Planning and Reproductive Health, 39(4). [Online]. Available: <http://www.ncbi.nlm.nih.gov/pubmed/23902713> [Accessed: 16/02/2016].
- Cambridge Dictionary Online. n.d. Sv "experience". [Online]. <https://dictionary.cambridge.org/dictionary/english/experience> [Accessed: 12/12/2014].
- Cambridge Dictionary Online. n.d. Sv "needs" [Online]. <https://dictionary.cambridge.org/dictionary/english/needs> [Accessed: 14/06/2013].
- Cambridge Dictionary Online. n.d. Sv "professional practitioner". [Online]. <https://dictionary.cambridge.org/dictionary/english/professional+practitioner> [Accessed: 12/02/2015].
- Cambridge Dictionary Online. n.d. Sv "rural". [Online]. <https://dictionary.cambridge.org/dictionary/english/rural> [Accessed: 04/04/2014].
- Cambridge Dictionary Online. n.d. Sv "semi-urban area". [Online]. <https://dictionary.cambridge.org/dictionary/english/semiurban+area> [Accessed: 04/04/2014].
- Cambridge Dictionary Online. n.d. Sv "urban". [Online]. <https://dictionary.cambridge.org/dictionary/english/urban> [Accessed: 04/04/2014].
- Campero, L., Walker, D., Atienzo, E.E. & Gutierrez, J.P. 2011. A quasi-experimental evaluation of parents as sexual health educators resulting in delayed sexual initiation and increased access to condoms. Journal of Adolescence, 34(2):215-223.

- Carcary, M. 2009. The Research Audit Trail – Enhancing Trustworthiness in Qualitative Enquiry. The Electronic Journal of Business Methods, 7(1):11-24. [Online]. Available: <http://www.ejbrm.com/search/index.html?name=keywords&value=%20research%20audit%20trail> [Accessed: 16/02/2016].
- Carter, S.M. & Little, M. 2007. Justifying knowledge, justifying method, taking action: epistemologies, methodologies and methods in qualitative research. Qualitative Health Research, 17(10):1316-1328. [Online]. Available: <https://journals.sagepub.com/doi/abs/10.1177/1049732307306927> [Accessed: 15/02/2016].
- Case, A., Hosegood, V. & Lund, V. 2004. The reach and impact of Child Support Grants: Evidence from KwaZulu-Natal. Development Southern Africa, 22(4):467-482.
- Chan, Z.C.Y., Fung, Y. & Chien, W. 2013. Bracketing in phenomenology: Only undertaken in the data collection and analysis process? The Qualitative Report, 18(59):1-9.
- Charles, V.E., Polis, C.B., Sridhara, S.K. & Blum, R.W. 2008. Abortion and long-term health outcomes: a systematic review of the evidence. Contraception, 78(2008):436-450.
- Chesebro, J.W. & Borisoff, D.J. 2007. What Makes Qualitative Research Qualitative? Qualitative Research Reports in Communication, 8(1):3–14
- Chickering, A.W. & Schlossberg, N.K. 1995. Getting the Most Out of College. Needham Heights: Allyn and Bacon.
- Christians, C.G. 2005. Ethics and politics in qualitative research. In: Desnzin, N.K. & Lincoln, Y.S. (Eds). The SAGE handbook of qualitative research. London: SAGE: 981.
- Christofides, N.J., Jewkes, R. K., Dunkle, K.L., McCarty, F., Shai, N.J., Nduna, M. & Sterk, C. 2014. Risk factors for unplanned and unwanted teenage pregnancies occurring over two years of follow-up among a cohort of young South African women. Global Health Action, 7. [Online]. Available: <https://www.ncbi.nlm.nih.gov/pubmed/25150027> [Accessed: 16/02/2016].

- Clark, T. 2010. Gaining and maintaining access: Exploring the mechanisms that support and challenge the relationship between gatekeepers and researchers. [Online]. Available: <http://gsw.sagepub.com/content/10/4/485.full.pdf+html> [Accessed: 22/01/2016].
- Coetzee, M.H. & Ngunyulu, R.N. 2015. Assessing the use of contraceptives by female undergraduate students in a selected higher educational institution in Gauteng. Curationis, 38(2). [Online]. Available: <http://www.curationis.org.za/index.php/curationis/article/view/1535>. [Accessed: 18/01/2016].
- Cohen, S. & Williamson, G. 1988. Perceived Stress in a Probability Sample of the United States. In: Spacapan, S. & Oskamp, S. (Eds.) The Social Psychology of Health. Newbury Park, CA: SAGE: 1988.
- Cohen, S.M., Gerding, D.N., Johnson, S., Kelly, C.P., Loo, V.G., MacDonald, L.C., Pepin, J. & Wilcox, M.H. 2010. Clinical Practice Guidelines for Clostridium Infection in Adults. Infection Control Hospital Epidemiology, 31(5):431-455.
- Coleman, P.K., Boswell, K., Etzkorn, K. & Turnwald, R. 2017. Women who suffered emotionally from abortion: A qualitative synthesis of their experiences. Journal of American Physicians and Surgeons, 22(4):113-118.
- Collins, S., Coffey, M. & Morris, L. 2010. Social work students: Stress, support and wellbeing. British Journal of Social Work, 40:963-982.
- Combes, P., Gaillard, M., Pellet, J. & Demongeot, J. 2004. A score for measurement of the role of social vulnerability in decisions on abortion. European Journal of Obstetrics and Gynaecology and Reproductive Biology, 117(2004):93-101.
- Corkin, D. 2011. Student Perceptions of the Support Services Provided by the Teen Pregnancy and Parenting Program in 2010-2011. Evaluation Brief, 6(1):1-7.
- Craig, A.P. & Richter-Strydom, L.M. 1983. Unplanned pregnancy among urban Zulu schoolgirls. SA Medical Journal, 63:452-455.
- Creswell, J.W. & Poth, C.N. 2017. Qualitative inquiry and research design. Choosing among five approaches. 4th Edition. London: SAGE.
- Creswell, J.W. 1994. Research design: qualitative and quantitative approaches. London: SAGE.

- Creswell, J.W. 2003. Research design: Qualitative, quantitative and mixed methods approaches. 2nd Edition. Thousand Oaks, CA: SAGE.
- Creswell, J.W. 2007. Qualitative inquiry & research design: choosing among five approaches. Thousand Oaks, CA: SAGE.
- Creswell, J.W. 2009. Research design: Qualitative, quantitative and mixed methods approaches. 3rd Edition. Thousand Oaks, CA: SAGE.
- Creswell, J.W. 2014. Research design: Qualitative, quantitative and mixed methods approaches. 4th Edition. Thousand Oaks, CA: SAGE.
- Creswell, J.W. 2016. 30 Essential skills for qualitative researchers. London: SAGE.
- Creswell, J.W., Hanson, W.E. & Plano Clark, V.L. 2007. Qualitative research designs: selection and implementation. The Counselling Psychologist, 35(2):236-264.
- Crisis Pregnancy Care Centre, Management and Staff, Pretoria. 2009. Meetings. 14 & 26 October, 9 November. Pretoria.
- Crisis Pregnancy Care Centre, Management and Staff, Pretoria. 2014. Meeting, 22 August. Pretoria.
- Crisis Pregnancy Care Centre, Volunteer counsellors, Pretoria. 2009. Round table discussion, 14 October. Pretoria.
- Crisis Pregnancy Care Centre, Volunteer counsellors, Pretoria. 2014. Round table discussion, 14 August. Pretoria.
- Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. 2011. The case study approach. BMC Medical Research Methodology, 11(100). [Online]/ Available: <http://doi.org/10.1186/1471-2288-11-100> [Accessed: 17/05/2017].
- Cunico, L., Sartori, R., Maragnolli, O. & Meneghini, A.M. 2012. Developing empathy in nursing students: A cohort longitudinal study. Journal of Clinical Nursing, 21(13-14):2016-2025.
- Curley, M. & Johnston, C. 2013. The characteristics and severity of psychological distress after abortion among university students. Journal of Behavioural Health Services & Research, 40(3):279-293.
- Curtis, A.C. 2015. Defining Adolescence. Journal of Adolescent and Family Health, 7(2). [Online]. Available: <https://scholar.utc.edu/jafh/vol7/iss2/2/> [Accessed: 14/03/2015].

- D'Cruz, H. & Jones, M. 2014. Social work research in practice: Ethical and political contexts. 2nd Edition. London: SAGE.
- Dahlbäck, E., Maimbolwa, M., Kasonka, L., Bergström, S. & Ransjö-Arvidson, A. 2007. Unsafe induced abortions among adolescent girls in Lusaka. Health Care for Women International, 28(7):654-676
- Daley, A.M. 2012. Rethinking School-Based Health Centers as Complex Adaptive Systems: Maximizing Opportunities for the Prevention of Teen Pregnancy and Sexually Transmitted Infections. Advances in Nursing Science, 35(2):37-46.
- De Lange, N. & Geldenhuys, J.L. 2001. A systemic approach to adolescents' experiences of terminating their pregnancies. Society in Transition, 32(2):246-259.
- De Puy, C. & Dovitch, D. 1997. The Healing Choice. Your guide to emotional recovery after an abortion. Australia: Hodder & Stoughton.
- De Vos, A.S. 2005. Qualitative Data Analysis and Interpretation. In: De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. 2005. Research at grass roots for the social sciences and human service professions. 3rd Edition. Pretoria: Van Schaik: 333-349.
- De Vos, A.S., Schulze, S. & Patel, L. 2005. The sciences and the professions. In: De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. Research at grass roots for the social sciences and human service professions. 3rd Edition. Pretoria: Van Schaik: 8-28.
- De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. 2002. Research at the grass roots for the social sciences and human service professions. 2nd Edition. Pretoria: Van Schaik.
- De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. 2011. Research at grass roots for the social sciences and human service professions. 4th Edition. Pretoria: Van Schaik.
- De Vos, D. 2013. Surveys in Social Research. 6th Edition. London: Routledge.
- Dempsey, L., Dowling, M., Larkin P. & Murphy, K. 2016. Sensitive interviewing in qualitative research. Research in Nursing & Health, 39:480-490.
- Denscombe, M. 2012. Research Proposals: A practical guide. Berkshire: Open University Press.

- Denzin, N.K. & Lincoln, Y.S. 2005. The SAGE Handbook of Qualitative Research. Thousand Oaks, CA: SAGE.
- Department of Education. 2007. Measures for the Prevention and Management of Learner Pregnancy. [Online]. Available: <https://www.naptosa.org.za/doc-manager/40-professional/46-general/105-sgb-dbe-pregnancy-2007/file> [Accessed: 16/10/2015].
- Department of Education. 2017. Annual School Survey reporting 2015 – 2016. Pretoria: Department of Education.
- Department of Health. 2007. South African Demographic & Health Survey 2003. [Online]. Available: <https://dhsprogram.com/pubs/pdf/FR206/FR206.pdf> [Accessed: 15/03/2012].
- Department of Health. 2017a. National Adolescent and Youth Health Policy 2017. Pretoria: Government Printer.
- Department of Social Development. 2005. The Integrated Service Delivery Model for Developmental Social Services. Pretoria: Government Printer.
- Department of Social Development. 2013. Framework for Social Welfare Services. Pretoria: Government Printer.
- Department of Social Development. 2018. Foster Care. [Online]. Available: <https://www.gov.za/services/adopt-child/foster-care> [Accessed: 01/11/2018].
- Desai, V. & Potter, B.P. 2006. Doing development research. London: SAGE.
- Devers, K.J. & Frankel, R.M. 2000. Study design in qualitative research-2: Sampling and data collection strategies. Education for Health, 13(2):263-271.
- Dhludhlu, S. & Lombard, A. 2017. Challenges of statutory social workers in linking foster care services with socio-economic development programmes. Social Work/Maatskaplike Werk, 53(2):165-185.
- Didaba, Y., Fantahun, M. & Hindin, M.J. 2013. The association of unwanted pregnancy and social support with depressive symptoms in pregnancy: evidence from rural Southwestern Ethiopia. Pregnancy and Childbirth, (13):135-142.
- Dinkelman, T., Lam, D. & Leibbrandt, M. 2008. Linking poverty and income shocks to risky sexual behavior: evidence from a panel study of young adults in Cape Town. South African Journal of Economics, 76:52-74.

- DISA Sexual and Reproductive Health Clinic. n.d. Home Page. [Online]. Available: <http://www.safersex.co.za> [Accessed: 21/10/2009 & 04/01/2016].
- Donalek, J.G. & Soldwisch, S. 2004. An Introduction to Qualitative Research Methods. Urologic Nursing, 24(4):354-356.
- Du Preez, M.S.E. & Alpaslan, A.H. 1992. Die gebruik van funksionele hulpmiddels in maatskaplike werk. Social Work/Maatskaplike Werk, 28(1):19-27.
- Dunkel, C.S. & Harbke, C. 2017. A review of measures of Erikson's stages of psychosocial development: Evidence for a general factor. Journal of Adult Development, 24:58-76.
- Dunkle, K.L., Jewkes, R.K., Brown, H.C., Gray, G.E., McIntyre, J.A. & Harlow, S.D. 2004. Prevalence and patterns of gender-based violence and revictimization among women attending antenatal clinics in Soweto, South Africa. American Journal of Epidemiology, 160(3):230-239.
- Eagle, G.T. 1998. An integrative model for brief term intervention in the treatment of psychological trauma. International Journal of Psychology, 3(2):135-146.
- East, P.L., Khoo, S.T. & Reyes, B.T. 2006. Risk and protective factors predictive of adolescent pregnancy: A Longitudinal, prospective study. Applied Developmental Science, 10:188-199.
- Edwards, R. & Holland, J. 2013. What is qualitative interviewing? London: Bloomsbury.
- Ehlers, V.J. & Netshikweta, M.L. 2002. Problems experienced by pregnant student nurses in the Republic of South Africa. Health Care for Women International, 23:71-83.
- Ekstrand, M., Tydén, T., Darj, E. & Larsson, M. 2009. An illusion of power: Qualitative perspectives on abortion decision-making among teenage women in Sweden. Perspectives on Sexual and Reproductive Health, 41(3):173-180.
- Ellis, R.A. & Bliuc, A. 2016. An exploration into first-year university students' approaches to inquiry and online technologies in blended environments. British Journal of Educational Technology, 47(5):970-980.
- Englander, M. 2012. The interview: Data collection in descriptive phenomenological human scientific research. Journal of Phenomenological Psychology, 43:13–35.
- Erikson, E.H. (Ed.) 1963. Youth: Change and Challenge. New York, NY: Basic Books.
- Erikson, E.H. 1982. The life cycle completed. New York, NY: Norton.

- Evans, N.J., Forney, D.S. & Guido-Dibrito, F. 1998. Student Development in College: Theory, Research and Practice. San Francisco, CA: Josey-Bass.
- Fatusi, A.O. & Hindin, M.J. 2010. Adolescents and youths in developing countries: Health and development issues in context. Journal of Adolescence, 33(4):499-508.
- Faúndes, A., Rao, K. & Briozzo, L. 2009. Right to protection from unsafe abortion and postabortion care. International Journal of Gynaecology & Obstetrics, 106(2):164-167.
- Faure, S. & Loxton, H. 2003. Anxiety, depression and self-efficacy levels of women undergoing first trimester abortion. South African Journal of Psychology, 33(1):28-38.
- Feeny, B.C. & Collins, N.L. 2015. New look at Social Support: A Theoretical Perspective on Thriving through Relationships. Personality and Social Psychology Review, 19(2):113-147.
- Feldman, M.S., Bell, J. & Berger, M.T. 2003. Gaining Access. A practical and theoretical guide for qualitative researchers. Walnut Creek, CA: Altamira Press.
- Fergusson, D.M., Boden, J.M. & Horwood, L.J. 2007. Abortion among young women and subsequent life outcomes. Perspectives on Sexual and Reproductive Health, 39(1):6-12.
- Finer, L.B. & Henshaw, S.K. 2006. Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. Perspectives on Sexual and Reproductive Health, 38(2):90-96.
- Finlay, L. 2012. Unfolding Phenomenological Research Process: Iterative Stages of "Seeing Afresh". Journal of Humanistic Psychology, 53(2):172-201.
- Flick, U. 2007. Designing Qualitative Research. London: SAGE.
- Flick, U. 2015. Introducing research methodology: A beginner's guide to doing a research project. London: SAGE.
- Fortune, C.L. 2016. An overview of the foster care crisis in South Africa and its effect on the best interests of the child principle: A socio-economic perspective. MPhil research paper. Belville, University of the Western Cape.
- Fossey, E., Harvey, C., McDermott, F. & Davidson, L. 2002. Understanding and evaluating qualitative research. Australian and New Zealand Journal of Psychiatry, (36):717-732.

- Foster, D., Higgins, J.A., Karasek, D., Ma, S. & Grossman, D. 2012. Attitudes toward unprotected intercourse and risk of pregnancy among women seeking abortion. Woman's Health Issues, 22(2):149-155.
- Fotso, J. C., Izugbara, C., Saliku, T., & Ochako, R. 2014. Unintended pregnancy and subsequent use of modern contraceptive among slum and non-slum women in Nairobi, Kenya. BMC Pregnancy and Childbirth, 14:224. [Online]. Available: <http://doi.org/10.1186/1471-2393-14-224> [Accessed: 12/03/2015].
- Fox, W. & Bayat, M.S. 2007. A guide to managing research. Cape Town: Juta.
- Frankel, R.M. & Devers, K.J. 2000. Study design in qualitative research-1: Developing questions and assessing resource needs. Education for Health, 13(2):251-261.
- Franz, W. & Reardon, D. 1992. Differential impact of abortion on adolescents and adults. Adolescence, 27(105):161-174.
- Frederico, M., Michielsen, K., Arnaldo, C., & Decat, P. 2018. Factors Influencing Abortion Decision-Making Processes Among Young Women. International Journal of Environmental Research and Public Health, 15(2):329-342.
- Freed, L. & Salazar, P.Y. 1993. A Season to heal: Help and hope for those working through post-abortion stress. Nashville: Cumberland House Publishing.
- French, V.A., Steinauer, J.E. & Kimport, K. 2017. What women want from their health care providers about pregnancy options counseling: A qualitative study. Women's Health Issues, 27(6):715-720.
- Gama, N.N. 2008. The effects of unplanned pregnancy of female students of the University of Zululand. M.A. dissertation in Social Work. Empangeni, University of Zululand.
- Gatter, M., Kimport, K., Foster, D., Weitz, T. & Upadhyay, U.D. 2014. Relationship between ultrasound viewing and proceeding to abortion. Obstetrics & Gynecology, 123(1):81-87.
- Gelaye, A.A., Taye, K.N. & Mekonen, T. 2014. Magnitude and risk factors of abortion among regular female students in Wolaita Sodo University, Ethiopia. BMC Women's Health, 14:50. [Online]. Available: <https://bmcwomenshealth.biomedcentral.com/articles/10.1186/1472-6874-14-50> [Accessed: 07/07/2016].
- Geller, P.A. 2004. Pregnancy as a stressful life event. CNS Spectrums, 9(3):188-197.

- Gold, R.B. 2005. The Implications of Defining When a Woman Is Pregnant. [Online]. Available: https://www.guttmacher.org/sites/default/files/article_files/gr080207.pdf [Accessed: 04/04/2012].
- Gomez-Scott, J. & Cooney, T.M. 2014. Young women's education and behavioural risk trajectories: clarifying their association with unintended pregnancy resolution. Culture, Health & Sexuality, 16(6):648-665.
- Goodwin, P. & Ogden, J. 2007. Women's reflections upon their past abortions: An exploration of how and why emotional reactions change over time. Psychology and Health, 22(2):231-248.
- Gouws, E., Kruger, N. & Burger, S. 2008. The Adolescent. 3rd Edition. Johannesburg: Heinemann Publishers.
- Grant, C. & Osanloo, A. 2014. Understanding, selecting and integrating a theoretical framework in dissertation research: creating a blueprint for your "house". Administrative Issues Journal: Connecting Education, Practice and Research, 4(2):12-26.
- Grant, M. & Hallman, K. 2006. Pregnancy-related school dropout and prior school performance in KwaZulu Natal, South Africa. *Studies in Family Planning*, 39(4):369-382.
- Green, H.S. 2014. Use of theoretical and conceptual frameworks in qualitative research. Nurse Researcher, 21(6):34-38.
- Grey, J.B. 2014. Social support communication in unplanned pregnancy: support types, messages, sources and timing. Journal of Health Communication, 19(10):1196-1211.
- Grey, J.B. 2015. "It has been a long journey from first knowing": Narratives of Unplanned Pregnancy. Journal of Health Communication, 20(6):736-742.
- Grinnell, R.M. & Unrau, Y.A. 2008. Social work research and evaluation: Foundations of Evidence-based practice. New York, NY: Oxford University Press.
- Grinnell, R.M. & Unrau, Y.A. 2011. Social work research and evaluation: Foundations of Evidence-based practice. 9th Edition. New York, NY: Oxford University Press.
- Grinnell, R.M. 2001. Social work research and evaluation: quantitative and qualitative approaches. New York, NY: F.E. Peacock.

- Grossoehme, D.H. 2014. Research methodology: Overview of qualitative research. Journal of Health Care Chaplaincy, 20(3):109-122.
- Grove, S.K., Burns, N. & Gray, J.R. 2013. The practice of nursing research: appraisal, synthesis and generation of evidence. 7th Edition. Missouri: Elsevier.
- Grussu, P., Quatraro, M. & Nasta, M.T. 2005. Profile of Mood States and Parental Attitudes in Motherhood: Comparing women with planned and unplanned pregnancies. Birth, 32(2):107-114.
- Guest, G., Namey, E.E. & Mitchell, M.L. 2013. Collecting Qualitative Data: A field manual for applied research. Los Angeles, CA: SAGE.
- Guttmacher Institute. n.d. An overview of Minors' Consent Law. [Online]. Available: http://www.guttmacher.org/statecenter/spibs/spib_OMCL.pdf [Accessed on 14/03/2013].
- Haberland, N. & Rogow, D. 2015. Sexuality Education: Emerging trends in Evidence and Practice. Journal of Adolescent Health, 56(1S):15-21.
- Haffejee, F., O'Connor, L., Govender, N., Reddy, P., Sibiyi, M.N., Ghuman, S., Ngxongo, T. & Borg, D. 2018. Factors associated with unintended pregnancy among women attending a public health facility in KwaZulu-Natal, South Africa. South African Family Practice, 60(3):79-83.
- Hall, K.S., Dalton, V.K., Zochowski, M., Johnson, T.R.B. & Harris, L.H. 2017. Stressful life events around the time of unplanned pregnancy and women's health: Exploratory findings from a national sample. Maternal and Child Health Journal, 21(6):1336–1348.
- Harries, J., Cooper, D., Strebel, A. & Colvin, C.J. 2014. Conscientious objection and its impact on abortion service provision in South Africa: A qualitative study. Reproductive Health, 11:16.
- Harries, J., Gerdt, C., Momberg, M. & Greene Foster, D. 2015. An exploratory study of what happens to women who are denied abortions in Cape Town, South Africa. Reproductive Health, 12(21):1-6.
- Health Systems Trust. n.d. Home Page. [Online]. Available: www.hst.org.za [Accessed: 09/01/2016]
- Healthcare Professional, Tertiary Institution A, Pretoria. 2009. Telephone interview, 24 September. Pretoria.

- Healthcare Professional, Tertiary Institution B, Pretoria. 2009. Telephone interview, 5 October. Pretoria.
- Heath, C. 2004. Analysing face-to-face interaction. In: Silverman, D. Qualitative research: theory, method and practice. London: SAGE: 266-282.
- Hennink, M., Hutter, I. & Bailey, A. 2011. Qualitative Research Methods. Los Angeles, CA: SAGE.
- Hepworth, D.H., Rooney, R.H., Rooney, G.D., Strom-Gottfried, K. & Larsen, J.A. 2013. Direct Social Work Practice: Theory and Skills. 8th Edition. Toronto: Brooks/Cole.
- Higher Education Learning and Teaching Association of South Africa. 2006. Statement by Ms Naledi Pandor, MP, Minister of Education. *Annual National Conference of the Higher Education Learning and Teaching Association of South Africa (HELTASA)*, 27-29 November. Pretoria.
- Hill, B.J. 2015. Casey Meets the Crisis Pregnancy Centers. Journal of Law, Medicine & Ethics, 43(1):59-71.
- Hodes, R. 2016. The culture of illegal abortion in South Africa. Journal of South African Studies, 42(1):79-93.
- Hollander, D. 2002. Parents are youngster's top choice as source of health information. Perspectives on sexual and reproductive health, 34(2):110-111. [Online]. Available: <https://www.poline.org/node/187867> [Accessed: 21/11/2010].
- Holloway, I. & Wheeler, S. 2010. Qualitative research in nursing and health care. 3rd Edition. Oxford: Blackwell Science.
- Holmberg, L.I. & Wahlberg, V. 2007. Young men and unplanned pregnancy – risk behaviour and reactions: their own narratives. In: Wahlberg, V. Memories after abortion. UK: Radcliffe Publishing: 838-846.
- Hoque, M.E. & Ghuman, S. 2012. Knowledge, Practices, and Attitudes of Emergency Contraception among Female University Students in KwaZulu-Natal, South Africa. PLoS ONE, 7(9). [Online]. Available: <https://www.ncbi.nlm.nih.gov/pubmed/23050018> [Accessed: 04/03/2015].

- Hornberger, L.L. 2017. Options counselling for the pregnant adolescent patient. *Pediatrics*, 140(3). [Online]. Available: <http://pediatrics.aappublications.org/content/140/3/e20172274> [Accessed: 16/03/2017].
- Human Sciences Research Council. 2008. Roundtable 5: Pregnancy. [Online]. Available: <http://www.hsrc.ac.za/en/research-areas/Child-Youth-Family-and-Social-Development/youth-policy-initiative/roundtable-5> [Accessed: 14/02/2013].
- Humanity's Team South Africa. n.d. What is Ubuntu. [Online]. Available: <http://www.humanitysteamsa.org/ubuntu/> [Accessed: 22/01/2019].
- Hume, J. & Leonard, A. 2014. Exploring the strategic potential of internal communication in international non-governmental organisations. *Public Relations Review*, 40(2):294-3-4.
- Ibisomi, L.D.G., & Odimegwu, C.O. 2007. Predictors of unintended pregnancy among South African youth. *Contraception*, 79:61-80.
- International Federation of Social Workers. 2012. Global Standards. [Online]. Available: <https://www.ifsw.org/global-standards/> [Accessed: 14/11/2014].
- International Pregnancy Advisory Services. n.d. Home Page. [Online]. Available: <http://www.ipas.org> [Accessed: 21/02/2014].
- Ireland, L.D., Gatter, M. & Chen, A.Y. 2015. Medical compared with surgical abortion for effective pregnancy termination in the first trimester. *Obstetrics & Gynaecology*, 126(1):22-28.
- Isdale, K., Reddy, V., Winnaar, L. & Zuze, L. 2016. Smooth, Staggered or Stopped? Educational Transitions in the South African Panel Study. [Online]. Available: http://www.lmip.org.za/sites/default/files/documentfiles/HSRC%20LMIP%20Report%20027%20WEB_0.pdf [Accessed: 16/03/2017].
- Ivanovic, M., Swift, J.K. & Callahan, J.L. 2015. A multisite pre/post study of mindfulness training for therapists: The impact on sessions presence and effectiveness. *Journal of Cognitive Psychotherapy*, 29(4):331-342.
- James, R.K. & Gilliland, B.E. 2012. Crisis Intervention Strategies. 7th Edition. Belmont, CA: Brooks/Cole.
- Jenkins, R. 2014. Social Identity. 4th Edition. UK: Routledge

- Jewkes, R. & Christofides, N. 2008. Teenage pregnancy: Rethinking prevention. Paper prepared for the HSRC Youth Policy Initiative Roundtable 5: Teenage Pregnancy. Pretoria: Reserve Bank.
- Jewkes, R.K., Dunkle, K., Nduna, M. & Shai, N. 2010. Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. The Lancet, 376(3):41-48.
- Johl, S.K. & Renganathan, S. 2010. Strategies for gaining access in doing fieldwork: Reflection of two researchers. The Electronic Journal of Business Research Methods, 8(1):42-50.
- Johnson, F.A., & Madise, N.J. 2010. Targeting women at risk of unintended pregnancy in Ghana: Should geography matter? Sexual & Reproductive Healthcare, 39:1-7.
- Jordan, N., Patel, L. & Hochfeld, T. 2014. Early motherhood in Soweto: The nexus between the Child Support Grant and developmental social work services. Social Work/Maatskaplike Werk, 50(3):392-409.
- Jordán-Conde, Z., Mennecke, B. & Townsend, A. 2014. Late adolescent identity definition and intimate disclosure on Facebook. Computers in Human Behavior, 33:356-366.
- Kaaya, S.F., Flisher, A.J., Mbwambo, J.K., Schaalma, H., Aarø, L.E. & Klepp, K. 2002. A review of studies of sexual behaviour of school students in sub-Saharan Africa. Scandinavian Journal of Public Health, 30:148-160.
- Kaufman, C.E., Clark, S., Manzini, N. & May, J. 2004. Communities, opportunities, and adolescents' sexual behavior in KwaZulu Natal, South Africa. Studies in Family Planning, 35:261-274.
- Kaur, S. 2016. Student support services in higher education: A student perspective. The International Journal of Indian Psychology, 3(3):126-132.
- Kearney, M.S. & Levine, P.B. 2007. Socio-Economic Disadvantage and Early Childbearing. Cambridge: National Bureau of Economic Research.
- Kelly, K. 2012. In the name of the mother: Renegotiating conservative women's authority in the crisis pregnancy centre management. Signs: Journal of Women in Culture and Society, 38(1):203-230.
- Kero, A., Högberg, U. & Lalos, A. 2004. Wellbeing and mental growth- long-term effects of legal abortion. Social Science and Medicine, 58(2004):2559-2569.

- Kilander, H., Bertero, C., Thor, J., Brynhildsen, J. & Alehagen, S. 2018. Women's experiences of contraceptive counselling in the context of an abortion – An interview Study. Sexual & Reproductive Healthcare, 17:103-107.
- Kilwein, T.M. & Looby, A. 2017. Predicting risky sexual behaviors among college student drinkers as a function of event-level drinking motives and alcohol use. Addictive Behaviours, 76:100-105.
- King, N. & Horrocks, C. 2010. Interviews in qualitative research. Los Angeles, CA: SAGE.
- Kirby, D. 2002. Antecedents of adolescent initiation of sex, contraceptive use, and pregnancy. American Journal of Health Behavior, 26:473-485.
- Kirby, D. 2007. Emerging Answers 2007: Research findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases. Washington, DC: The National Campaign to Prevent Unplanned Pregnancy.
- Kissen, D.M., Anderson, E.J., Kraft, J.M., Warner, L. & Jamieson, D.J. 2008. Is there a trend of increased unwanted childbearing among young women in the United States? Journal of Adolescent Health, 43:364-371.
- Kjelsvik, M. & Gjengedal, E. 2011. First-time pregnant women's experience of the decision-making process related to completing or terminating pregnancy – a phenomenological study. Scandinavian Journal of Caring Sciences, 25:169-175.
- Kline, A.C., Cooper, A.A., Rytwinski, N.K. & Feeny, N.C. 2018. Long-term efficacy of psychotherapy for posttraumatic stress disorder: A meta-analysis of randomized controlled trials. Clinical Psychology Review, 59:30-40.
- Knapen, J., Vancampfort, D., Moriën, Y. & Marchal, Y. 2015. Exercise therapy improves both mental and physical health in patients with major depression. Disability and Rehabilitation, 37(16):1490-1495.
- Knight, Z.G. 2017. A proposed model of psychodynamic psychotherapy linked to Erik Erikson's eight stages of psychosocial development. Clinical Psychology & Psychotherapy, 24:1047–1058.
- Koerber, A. & McMichael, L. 2008. Qualitative sampling methods: A primer for technical communicators. Journal of Business and Technical Communication, 22(4):454-473.
- Kramer-Kile, M.L. 2012. Situating methodology within qualitative research. Canadian Journal of Cardiovascular Nursing, 22(4):27-31.

- Krefting, L. 1991. Rigor in qualitative research: The assessment of trustworthiness. American Journal of Occupational Therapy, 45(3):214-222.
- Kroenke, K., Spitzer, R.L. & Williams, J.B. 2001. The PHQ-9: Validity of a brief depression severity measure. Journal of General Internal Medicine, 16(9):606-613.
- Kübler-Ross, E. 1969. On death and dying. New York: Macmillan.
- Kumar, R. 2010. Research methodology. A step by step guide for beginners. 3rd Edition. Thousand Oaks, CA: SAGE.
- Kumar, R. 2015. Research methodology. A step by step guide for beginners. 4th Edition. Thousand Oaks, CA: SAGE.
- Lane, J.A. 2015. Counseling emerging adults in transition: Practical implications of attachment and social support research. The Professional Counselor, 5(1):30-42.
- Lang, F., Joubert, G. & Prinsloo, E. 2005. Is pregnancy termination being used as a family planning method in the Free State? SA Family Practice, 47(5):52-55.
- Leask, M. 2015. An exceptional choice? Australian Feminist Studies, 30(84):179-198.
- Lee, W.M.L., Blando, J.A., Mizelle, N.D. & Orozco, G.L. 2010. Introduction to multicultural counseling for helping professionals. 2nd Edition. New York, NY: Routledge.
- Leedy, P.D. & Ormrod, J.E. 2005. Practical research: planning and designing. 8th Edition. New Jersey: Pearson Education International.
- Lenz, B. 2001. The transition from adolescence to young adulthood: A theoretical perspective. The Journal of School Nursing, 17(6):300-306.
- Levi, A.J., Simmonds, K.E. & Taylor, D. 2009. The role of Nursing in the Management of Unintended Pregnancy. Nursing Clinics of North America, 44(3):301-314.
- Levinson, D.J. 1986. A conception of adult development. American Psychologist, 41(1):3-13.
- Lichtman, M. 2014. Qualitative research for the Social Sciences. London: SAGE.
- Lietz, C.A. & Zayas, L.E. 2010. Evaluating qualitative research for social work practitioners. Advances in Social Work, 11(2):188-202.
- Likis, F.E. 2009. With Woman: Midwifery care of women with unintended pregnancies. Journal of Midwifery & Women's Health, 54(1):1-2.

- Lince-Deroche, N., Constant, D., Harries, J., Blanchard, K., Sinanovic, E. & Grossman, D. 2015. The costs of accessing abortion in South Africa: women's costs associated with second trimester abortion services in Western Cape Province. Contraception, 92(4):339-344.
- Lincoln, Y. & Guba, E. 1985. Naturalistic inquiry. Beverly Hills, CA: SAGE.
- Loh, J. 2013. Inquiry into issues of Trustworthiness and Quality in Narrative Studies: A perspective. The Qualitative Report, 18(65):1-15.
- Lohan, M., Cruise, S., O'Halloran, P., Alderdice, F. & Hyde, A. 2011. Adolescent men's attitudes and decision-making in relation to an unplanned pregnancy. Responses to an interactive video drama. Social Science & Medicine, 72:1507-1514.
- Longman Dictionary of Contemporary English. 2003. Sv "student". Harlow: Longman.
- LoveLife. 2012. Annual Report 2012. [Online]. Available: https://lovelife.org.za/en/annualreports/2012_loveLife_Annual_Report.pdf [Accessed: 03/03/2014].
- LoveLife. 2017. [Online]. Home Page. [Online]. Available: <https://lovelife.org.za/en/> [Accessed: 06/03/2017].
- Lovelock, R., Lyons, K.H. & Powell, J. 2004. Reflecting on social work – discipline and profession. England: Ashgate.
- Ma, Q., Ono-Kihara, M., Cong, L., Xu, G., Pan, X., Zamani, S., Ravari, S.M. & Kihara, M. 2008. Unintended pregnancy and its risk factors among university students in eastern China. Contraception, 77(2):108-113.
- Macagno, F. & Walton, D. 2014. Emotive language in Argumentation. New York, NY: Cambridge University Press.
- Mack, N., Woodsong, C., Macqueen, K.M., Guest, G. & Namey, E. 2005. Qualitative research methods: A data collector's field guide. North Carolina: Family Health International.
- Macleod, C. & Tracey, T. 2009. Review of South African Research and Interventions in the Development of a Policy Strategy on Teen-Aged Pregnancy. [Online]. Available: <https://tinyurl.com/ybk5sn37> [Accessed: 11/10/2011].
- Macleod, C. 2003. Teenage Pregnancy and the Construction of Adolescence: Scientific Literature in South Africa. Childhood, 10(4):419-437.

- Macleod, C. 2009. Danger and disease in sex education: The saturation of 'Adolescence' with Colonialist assumptions. Journal of Health Management, 11:375-389.
- Macleod, C., Chiweshe, M. & Mavuso, J. 2016. A critical review of sanctioned knowledge production concerning abortion in Africa: Implications for feminist health psychology. Journal of Health Psychology, 23(8):1096-1109.
- Macleod, C.I. & Tracey, T. 2010. A decade later: follow-up review of South African research on the consequences of and contributory factors in teen-aged pregnancy. South African Journal of Psychology, 40(1):18-31.
- Maçola, L., Do Vale, I.N. & Carmona, E.V. 2010. Assessment of self-esteem in pregnant women using Rosenberg's Self-Esteem Scale. Revista da Escola de Enfermagem da USP, 44(3):570-577.
- MacPhail, C. & Campbell, C. 2001. 'I think condoms are good but, aai. I hate those things': condom use among adolescents and young people in a Southern African township. Social Science and Medicine, 52:1613-1627.
- Mahlangu, T. & Silaule, T. 2009. The challenges of pregnant students at TUT. Unpublished dissertation. Pretoria, University of Pretoria.
- Major, B., Appelbaum, M., Beckman, L., Dutton, M.A., Russo, N.F. & West, C. 2009. Abortion and mental health: Evaluating the evidence. American Psychologist, 64(9):869-890.
- Makiwane, M. 2010. The child support grant and teenage childbearing in South Africa. Development Southern Africa, 27(2):193-204.
- Makiwane, M., Desmond, C., Richter, L.M. & Udjo, E. 2006. Is the Child Support Grant Associated with an Increase in Teenage Fertility in South Africa? Evidence from National Surveys and Administrative Data. Cape Town: HRSC Press.
- Mantell, J.E., Smit, J.A., Exner, T.M., Mabude, Z., Hoffman, S., Beksinska, M., Kelvin, E.A., Ngoloyi, C. & Leu, C. 2015. Promoting female condom use among female university students in KwaZulu-Natal, South Africa: Results of a randomized behavioral trial. AIDS and Behavior, 19(7):1129-1140.
- Manzini, N. 2001. Sexual initiation and childbearing among adolescent girls in KwaZulu Natal, South Africa. Reproductive Health Matters, 9(17):44-52.
- Maree, K. 2007. First steps in research. Pretoria: Van Schaik.

- Maree, K. 2016. First steps in research. 2nd Edition. Pretoria: Van Schaik.
- Marshall, C. & Rossman, G.B. 2016. Designing qualitative research. 6th Edition. London: SAGE.
- Marteleto, L., Lam, D. & Ranchhod, V. 2009. Sexual Behavior, Pregnancy, and Schooling among Young People in Urban South Africa. Studies in Family Planning, 39(4):351-368.
- Martin, J. & Oswin, F. 2010. Mental Health, Access and Equity in Higher Education. Advances in Social Work, 11(1):48-66.
- Martineau, R. 1997. Women and education in South Africa: Factors influencing women's educational progress and their entry into traditionally male dominated fields. Journal of Negro Education, 66(4):383-395.
- Martino, S.C., Collins, R.L., Ellickson, P.L. & Klein, D.J. 2006. Exploring the link between substance use and abortion: the roles of unconventionality and unplanned pregnancy. Perspectives on sexual and reproductive health, 38(2):66-75.
- Mathani, R.P. 2004. Application of qualitative research methodology for developing Social Work practice models. The Indian Journal of Social Work, 65(1):49-72.
- Mathews, C., Guttmacher, S.J., Flisher, A.J., Mtshizana, Y.Y., Nelson, T., McCarthy, J. & Daries, V. 2009. The quality of HIV testing services of adolescents in Cape Town, South Africa: Do adolescent-friendly services make a difference? Journal of Adolescent Health, 44:188-190.
- Matsolo, M.J., Ningpuenyeh, W.C. & Susuman, A.S. 2016. Factors affecting the enrolment rate of students in Higher Education in the Gauteng province, South Africa. Journal of Asian and African Studies, 53(1). [Online]. Available: <https://www.researchgate.net/publication/305639607> [Accessed: 14/14/2016].
- Mavis, F.S., Krishnamoorthy, N. & Dongre, A. 2015. Why women seek abortion? A qualitative study on perspectives of rural women on abortion and contraception. International Journal of Reproduction, Contraception, Obstetrics and Gynaecology, 4(4):1153-1157.
- Max-Neef, M.A. 1991. Human Scale Development: Conception, Application and Further Reflections. New York, NY: The Apex Press

- Maxwell, J.A. 2013. Qualitative research design: An interactive approach. 3rd Edition. London: SAGE.
- Mbelle, N., Mabaso, M., Setswe, G. & Sifunda, S. 2018. Predictors of unplanned pregnancies among female students at South African Technical and Vocational education and Training colleges: Findings from the 2016 Higher Education and Training HIV and AIDS survey. South African Medical Journal, 108(6):511-516.
- McBrien, C. 2008. Evidence-based care: enhancing the rigour of a qualitative study. British Journal of Nursing, 17(20):1286-1289.
- McDonagh, J.E. 2018. The age of adolescence... and young adulthood. The Lancet: Child and Adolescent Health, 2(4):e6. [Online]. Available: [https://doi.org/10.1016/S2352-4642\(18\)30079-8](https://doi.org/10.1016/S2352-4642(18)30079-8) [Accessed: 14/06/2018].
- Mchunu, G., Peltzer, K., Tutshana, B. & Seutlwadi, L. 2012. Adolescent pregnancy and associated factors in South African youth. African Health Sciences, 12(4):426-434.
- Mdleleni-Bookholane, T. 2007. Factors related to and the consequences of the termination of pregnancy at the Umtata General Hospital, Eastern Cape. South African Journal of Psychology, 37(2):245-259.
- Merriam, S.B. & Tisdell, E. 2016. Qualitative Research: A guide to design and implementation. 4th Edition. San Francisco, CA: Jossey-Bass.
- Merriam, S.B. 2009. Qualitative Research: A guide to design and implementation. San Francisco, CA: Jossey-Bass.
- Merriam-Webster Online Dictionary. n.d. Sv "needs". [Online]. Available: <http://www.merriam-webster.com/dictionary/needs> [Accessed: 14/06/2013].
- Merriam-Webster Online Dictionary. n.d. Sv "experience". [Online]. Available: <http://www.merriam-webster.com/dictionary/experience> [Accessed: 10/05/2010].
- Merriam-Webster Online Dictionary. n.d. Sv "psycho-education". [Online]. Available: <http://merriam-webster.com/dictionary/psycho-education> [Accessed: 15/06/2015].
- Merriam-Webster Online Dictionary. n.d. Sv "support". [Online]. Available: <http://www.merriam-webster.com/dictionary/support> [Accessed: 28/01/2014].
- Merrill, N., Waters, T.E.A. & Fivush, R. 2016. Connecting the self to traumatic and positive events: links to identity and well-being. Memory, 24(10):1321-1328.

- Mhlanga, R.E. 2003. Abortion: developments and impact in South Africa. British Medical Bulletin, 67:115–126.
- Miller, J. & Glassner, B. 2004. The “inside” and the “outside”: finding realities in interviews. In: Silverman, D. (Ed.) Qualitative research: theory, method and practice. London: SAGE: 125-139.
- Miller, L.M. 2011. College student knowledge and attitudes toward emergency contraception. Contraception, 83(1):68-73.
- Miller, W.B. 1992. An empirical study of the psychological antecedents and consequences of induced abortion. Journal of Social Issues, 48(3):67-93.
- Mills, J. & Birks, M. 2014. Introducing qualitative research. In: Mills, J. & Birks, M. (Eds). Qualitative methodology: A practical guide. London: SAGE: 69-110.
- Ministry of Education. 2001. Draft National Plan for Higher Education in South Africa. [Online]. Available: <http://www.dhet.gov.za/HED%20Policies/National%20Plan%20on%20Higher%20Education.pdf> [Accessed: 10/10/2015].
- Mlinac, M.E. & Feng, M.C. 2016. Assessment of activities of daily living, self-care and independence. Archives of Clinical Neuropsychology, 31(6):506-516.
- Mnyango, R.E. 2015. Post-divorce adjustment: Experiences, challenges and coping resources employed by men- A Social work perspective. DPhil dissertation in Social Work. Pretoria, University of South Africa.
- Moerer-Urdahl, T. & Creswell, J.W. 2004. Using transcendental phenomenology to explore the “ripple effect” in a leadership mentoring program. International Journal of Qualitative Methods, 3(2):190-35
- Mojapelo-Batka, E.M. & Schoeman, J.B. 2003. Voluntary termination of pregnancy: Moral concerns and emotional experiences among black South African adolescents. South African Journal of Psychology, 33(3):144-153.
- Monette, D.R., Sullivan, T.J. & DeJong, C.R. 2011. Applied Social Research: A tool for the human services. 8th Edition. USA: Brooks/Cole Cengage Learning.

- Moore, A.A., Overstreet, C., Kendler, K.S., Dick, D.M., Adkins, A. & Amstadter, A.B. 2017. Potentially traumatic events, personality, and risky sexual behavior in undergraduate college students. Psychological Trauma: Theory, Research, Practice, and Policy, 9(1):105-112.
- Morrow, S. 2007. Qualitative research in counselling psychology. The Counselling Psychologist, 35(2):209-235.
- Morse, J.M., Barrett, M., Mayan, M., Olson, K. & Spiers, J. 2002. Verification strategies for establishing reliability and validity in qualitative research. International Journal of Qualitative Methods, 1(2):13-22.
- Moscrop, A. 2013. 'Miscarriage or abortion?' Understanding the medical language of pregnancy loss in Britain: a historical perspective. Medical Humanities, 39(2):98-104. [Online]. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3841747/> [Accessed: 16/04/2016].
- Mosley, E.A., King, E.J., Schultz, A.J., Harris, L.H., De Wet, N. & Anderson, B.A. 2017. Abortion attitudes among South Africans: findings from the 2013 social attitudes survey. Culture, Health & Sexuality, 19(8):918-933. [Online]. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5849464/> [Accessed: 13/01/2017].
- Mota, N., Burnett, M. & Sareen, J. 2010. Associations between Abortion, Mental Disorders and Suicidal Behaviour in a Nationally Representative Sample. The Canadian Journal of Psychiatry, 55(4):239-247.
- Mothiba, T.M. & Maputle, M.S. 2012. Factors contributing to teenage pregnancy in the Capricorn district of the Limpopo Province. Curationis, 35(1):19-23.
- Mouton, J. 2009. Understanding Social Research. Pretoria: Van Schaik.
- Mphatswe, W., Maise, H. & Sebitloane, M. 2016. Prevalence of repeat pregnancies and associated factors among teenagers in KwaZulu-Natal, South Africa. International Journal of Gynaecology & Obstetrics, 133(2):152-155.
- Mpshe, W.S., Gmeiner, A. & Van Wyk, S. 2002. Experiences of black adolescents who chose to terminate their pregnancies, Health SA Gesondheid, 7(1):68-81.
- Murray, M. 2014. Factors affecting graduation and student dropout rates at the University of KwaZulu-Natal. South African Journal of Science, 110(11/12):1-6.

- Mwaba, K. & Naidoo, P. 2005. Sexual practices, attitudes toward premarital sex and condom use among a sample of South African university students. Social behaviour and personality, 33(7):651-656.
- Naidoo, P. & Kasiram, M. 2006. Exploring unplanned pregnancy amongst university students. Social Work / Maatskaplike Werk, 42(3/4):341-353.
- Naidoo, U., Zungu, L. & Hoque, M.E. 2013. Awareness, utilization and attitudes towards emergency contraception among women attending a primary health care clinic in Durban, South Africa. Biomedical Research, 24(3):341-34.
- National Association of Social Workers. n.d. Careers. [Online]. Available: <https://www.socialworkers.org/Careers> [Accessed: 14/06/2012].
- Nel, C. 2008. The transition from school to university: A theoretical framework for a pre-university intervention. DPhil dissertation in Education. Stellenbosch: University of Stellenbosch.
- Nelson. J.A. & O'Brien, M. 2012. Does an unplanned pregnancy have long-term implications to mother-child relationships? Journal of Family Issues, 33(4):506-526.
- Neuman, W.L. 2003. Social Research Methods: Qualitative and quantitative approaches. 5th Edition. Boston, MA: Allyn & Bacon.
- Neuman, W.L. 2006. Social Research Methods: Qualitative and quantitative approaches. 6th Edition. Boston, MA: Pearson Education.
- Neuman, W.L. 2012. Basics of Social Research: Qualitative and quantitative approaches. 3rd Edition. Boston, MA: Pearson Education.
- Nichols, J. 2009. Qualitative Research: Part Two – Methodologies. International Journal of Therapy and Rehabilitation, 16(11):586-592.
- Nsubuga, H., Sekandi, J.N., Sempeera, H. & Makumbi, F.E. 2016. Contraceptive use, knowledge, attitude, perceptions and sexual behavior among female University students in Uganda: a cross-sectional survey. BMC Women's Health, 16(6). [Online]. Available: <http://doi.org/10.1186/s12905-016-0286-6> [Accessed: 23/03/2017]
- O'Connor, B.N. & Cordova, R. 2010. Learning: The experiences of adults who work full-time while attending graduate school part-time. Journal of Education for Business, (85):359-368.

- O'Leary, Z. 2017. The essential guide to doing your research project. 3rd Edition. London: SAGE.
- O'Reilly, M. 2009. Careful counsel: Management of unintended pregnancy. Journal of the American Academy of Nurse Practitioners, 21:596-602.
- Oates, C. & Riaz, N.N. 2016. Accessing the field: Methodological difficulties of research in schools. Education in the North, 23(2):53-74.
- Oliphant, L. 2009. Social work top priority. City Press, March 22:12.
- Olukoya, A.A., Kaya, A., Fergusson, B.J. & AbouZahr, C. 2001. Unsafe abortions in adolescents. International Journal of Gynaecology & Obstetrics, 75(2001):137-147.
- Oosthuysen, D.M. & Mfomande, O. 2008. The perceptions of female students at TUT regarding unplanned pregnancy. Unpublished dissertation. Pretoria, University of Pretoria.
- Orij, V.K., Jeremiah, I. & Kasso, T. 2009. Induced abortion amongst undergraduate students of University of Port Harcourt. Nigerian Journal of Medicine, 18(2):199-202.
- Osario, A., Lopez-del Burgo, C., Ruiz-Canela, M., Carlos, S. & De Irala, J. 2015. Safe-sex belief and sexual risk behaviours among adolescents from three developing countries: a cross-sectional study. [Online]. BMJ Open, 5(4):E007826. Available: <http://doi.org/10.1136/bmjopen-2015-007826> [Accessed: 14/04/2016].
- Oxford Dictionaries. n.d. Sv "surgical abortion". [Online]. Available: <https://en.oxforddictionaries.com/definition/surgical+abortion> [Accessed: 14/02/2013].
- Oxford Living Dictionaries. n.d. Sv "crisis pregnancy". [Online]. Available: <https://en.oxforddictionaries.com/definition/crisis+pregnancy> [Accessed: 12/12/2015].
- Oxford Living Dictionaries. n.d. Sv "elective abortion". [Online]. Available: <https://en.oxforddictionaries.com/definition/elective+abortion> [Accessed: 12/12/2013].
- Oxford Living Dictionaries. n.d. Sv "guidance". [Online]. Available: <https://en.oxforddictionaries.com/definition/guidance> [Accessed: 16/02/2014].
- Oxford Living Dictionaries. n.d. Sv "pregnancy". [Online]. Available: <https://en.oxforddictionaries.com/definition/pregnancy> [Accessed: 14/02/2013].
- Oxford Living Dictionaries. n.d. Sv "student". [Online]. Available: <https://en.oxforddictionaries.com/definition/student> [Accessed: 14/06/2013].

- Palanivelu, L.M. & Oswal, A. 2007. Contraceptive practices in women with repeat termination of pregnancies. Journal of Obstetrics and Gynaecology, 27(8):832-834.
- Panday, S., Makiwane, M., Ranchad, C. & Letsoalo, J. 2009. Teenage pregnancy in South Africa -with a specific focus on school-going learners (Commissioned by UNICEF). [Online]. Available: <http://repository.hsrb.ac.za/handle/20.500.11910/4711> [Accessed: 22/04/2014].
- Parker, I. & Schotter, J. (Eds). 2015. Deconstructing Social Psychology. Vol. 21. London: Psychology Press.
- Parker, S.L. 2009. A Personal Narrative: Journey through and unplanned pregnancy, the welfare system and the pursuit of higher education. Unpublished master's thesis in Social Work. Long Beach, CA, California State University.
- Parliamentary Monitoring Group. 2018. Draft: National Policy on the Prevention and Management of Learner Pregnancy. [Online]. Available: <https://pmg.org.za/policy-document/1158/> [Accessed: 15/06/2018].
- Patel, C.J. & Johns, L. 2009. Gender role attitudes and attitudes to abortion: Are there gender differences? The Social Science Journal, 46:493-505.
- Patel, C.J. & Kooverjee, T. 2009. Abortion and contraception: Attitudes of South African university students. Health Care for Women International, 30(6):550-568.
- Patel, C.J. & Myeni, M.C. 2008. Attitudes to abortion in a sample of South African female university students. Journal of Applied Social Psychology, 38:736-750.
- Patton, M.Q. 2002. Qualitative Research and Evaluation Methods. 3rd Edition. Thousand Oaks, CA: SAGE.
- Pearce, H. & Ayers, S. 2005. The expected child versus the actual child: implications for mother-baby bond. Journal of Reproductive and Infant Psychology, 23(1):89-102.
- Pease, B. 2011. Men in Social Work: Challenging or Reproducing an Unequal Gender Regime? Affilia, 26(4):406-418.
- Peila-Schuster, J.J. 2016. Supporting student transitions: integrating life design, career construction, happenstance, and hope. South African Journal of Higher Education, 20(3):54-67.
- Perakyla, A. 2004. Reliability and validity in research based on tapes and transcripts. In: Seale, C. (Ed.) Social Research Methods. London: Routledge: 289-307.

- Pestvenidse, E., Berdzuli, N., Lomia, N., Gagua, T., Umikashvili L. & Stray-Pedersen, B. 2016. Repeat induced abortions in Georgia – Characteristics of women with multiple pregnancy terminations: secondary analysis of the Reproductive Health Survey 2010. European Journal of Obstetrics, Gynaecology and Reproductive Biology, 205:85-90.
- Pettifor, A.E., Levandowski, B.A., MacPhail, C., Padian, N.S., Cohen, M.S. & Rees, H.V. 2008. Keeping them in school: the importance of education as a protective factor against HIV infection among young South African women. International Journal of Epidemiology, 37:1266-1273.
- Pettifor, A.E., Rees, H.V., Kleinschmidt, I., Steffenson, A.E., MacPhail, C., Hlongwa-Madikizela, L., Vermaak, K. & Padian, N.S. 2005. Young people's sexual health in South Africa: HIV prevalence and sexual behaviours from a nationally representative household survey. AIDS, 19:1525-1534.
- Petty, T. 2014. Motivating first-generation students to academic success and college completion. College Student Journal, 2:257-264.
- Philkill, C.R. & Walsh, S. 2002. Equipped to Serve. Caring for women in crisis pregnancies. A Volunteer Training Manual. South African Edition. Castle Rock, CO: ETS.
- Picavet, C., Goeneet, M. & Wijnen, C. 2013. Characteristics of women who have repeat abortions in the Netherlands. The European Journal of Contraception & Reproductive Health Care, 18(5):327-334.
- Pickles, C. 2012. Termination-of-Pregnancy Rights and Foetal Interests in Continued Existence in South Africa: The Choice on Termination of Pregnancy Act 92 of 1996. Potchefstroom Electronic Law Journal, 15(5). [Online]. Available: <http://ssrn.com/abstract=2233289> [Accessed: 29/01/2014].
- Poggenpoel, M. & Myburgh, C.P.H. 2006. The developmental implications of a termination of pregnancy on adolescents with reference to the girl and her partner. Education, 122(4):731-739.
- Pole, C. & Hillyard, S. 2016. Doing fieldwork. London: SAGE.
- Polkinghorne, D.E. 2005. Language and meaning: Data collection in qualitative research. Journal of Counselling Psychology, 52:137-145.
- Posel, D. & Ross, F.C. 2014. Ethical Quandaries in Social Science Research. Cape Town: Human Science Research Council.

- Potter, S. 2002. Doing Postgraduate Research. London: SAGE.
- Private Healthcare UK. 2008. *Record numbers of women having multiple abortions*. [Online]. Available: <http://www.privatehealth.co.uk> [Accessed: 06/10/2009].
- Proctor, E.K. & Rosen, A. 2003. Developing practice guidelines for social work intervention: Issues, methods and research agenda. New York, NY: Columbia University Press.
- Pugh, A.N. 2010. Adoption is an option: A personal narrative. Unpublished thesis. Long Beach, CA, California State University.
- Pugh, E. 2010. Student pregnancy and maternity: implications for higher education institutions. Equality Challenge Unit. [Online]. Available: <https://www.ecu.ac.uk/wp-content/uploads/external/student-pregnancy-and-maternity-implications-for-heis.pdf> [Accessed: 14/07/2013].
- Punch, K.F. 2016. Developing effective research proposals. 3rd Edition. London: SAGE.
- Rahman, M., Rahim, N.A. & Arif, M.T. 2017. Barrier, weakness and utilization of pre-pregnancy clinic services. Archives of Public Health, 75:67-77.
- Ralph, L., Gould, H., Baker, A. & Foster, D. 2014. The role of parents and partners in minors' decisions to have an abortion and anticipated coping after abortion. Journal of Adolescent Health, 54(4):428-434.
- Ramathuba, D.U., Khoza, L.B. & Netshikweta, M.L. 2012. Knowledge, attitudes and practice of secondary school girls towards contraception in Limpopo. Curationis, 35(1):1-7. [Online]. Available: <https://curationis.org.za/index.php/curationis/article/view/45/66> [Accessed: 10/02/2016].
- Ratlabala, M.E., Makofane, M.D.M. & Jali, M.N. 2007. Perceptions of adolescents in low resourced areas towards pregnancy and the choice on termination of pregnancy (CTOP). Curationis, 30(1):26-31.
- Ravitch, S.M. & Riggan, M. 2017. Reason & Rigor. 2nd Edition. London: SAGE.
- Razzaque, R., Okoro, E. & Wood, L. 2015. Mindfulness in Clinician Therapeutic Relationships. Mindfulness, 6(2):170-174.
- Reardon, D., Cogle, J., Rue, V., Shuping, M., Coleman, P. & Ney, P. 2003. Psychiatric admissions of low-income women following abortion and childbirth. Canadian Medical Association, 168(10):1253.

- Reavley, N.J., McCann, T.V., Cvetkovski, S. & Jorm, A.F. 2014. A multifaceted intervention to improve mental health literacy in students of a multicampus university: a cluster randomised trial. Social Psychiatry and Psychiatric Epidemiology, 49(10):1655-1666.
- Reidy, D.E., Brookmeyer, K.A., Gentile, B., Berke, D.S. & Zeichner, A. 2016. Gender Role Discrepancy Stress, High-Risk Sexual Behavior, and Sexually Transmitted Disease. Archives of Sexual Behaviour, 45(2):459-465.
- Rek, I. & Dinger, U. 2016. Who sits behind the telephone? Interpersonal characteristics of volunteer counselors in telephone emergency services. Journal of Counseling Psychology, 63(4):429-442.
- Reybold, L.E., Lammert, J.D. & Stribling, S.M. 2012. Participant selection as a conscious research method: Thinking forward and the deliberation of 'emergent' findings. Qualitative Research, 13(6):699-716.
- Richter, L.M., Norris, S.A. & Ginsburg, C. 2006. The silent truth of teenage pregnancies – Birth to Twenty cohort's next generation. South African Medical Journal, 96:1-2.
- Ricks, E.J., Strümpher, J. & Van Rooyen, D. 2010. A model for higher education campus health services. Health SA Gesondheid, 15(1). [Online]. Available: <https://hsag.co.za/index.php/hsag/article/view/508/533> [Accessed: 16/08/2016].
- Ritchie, J. & Lewis, J. 2003. Qualitative Research Practice: A guide for social science students and researchers. Thousand Oaks, CA: SAGE.
- Ritchie, J. & Lewis, J. 2005. Qualitative research practice: a guide for social science students and researchers. Thousand Oaks, CA: SAGE.
- Ritchie, J., Lewis, J., McNaughton Nichols, C. & Ormston, R. 2014. Qualitative research Practice: A guide for social science students and researchers. 3rd Edition. Thousand Oaks, CA: SAGE.
- Roberts, C., Moodey, J. & Esterhuizen, T. 2004. Emergency contraception: knowledge and practices of tertiary students in Durban, South Africa. Journal of Obstetrics and Gynaecology, 24(4):441–445.
- Roberts, J., Fenton, G. & Barnard, M. 2015. Developing effective therapeutic relationships with children, young people and their families. Nursing Children and Young People, 27(4):30-35.

- Rocca, C.H., Kimport, K., Gould, H. & Foster, D.G. 2013. Women's emotions one week after receiving or being denied an abortion in the United States. Perspectives on Sexual and Reproductive Health, 45(3):122-131.
- Rocca, C.H., Kimport, K., Roberts, S.C.M., Gould, H., Neuhaus, J. & Foster, D.G. 2015. Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study. PLOS One, 10(7). [Online]. Available: <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0128832> [Accessed: 14/06/2016].
- Rochat, T.J., Mokomane, Z. & Mitchell, J. 2016. Public perceptions, beliefs and experiences of fostering and adoption: A national qualitative study in South Africa. Children & Society, 30(2):120-131.
- Rodda, S.N., Lubman, D.I., Cheetham, A., Dowling, N.A & Jackson, A.C. 2015. Single session web-based counselling: a thematic analysis of content from the perspective of the client. British Journal of Guidance & Counselling, 43(1):117-130.
- Romeo, K.E. & Kelly, M.A. 2009. Incorporating human sexuality content into a positive youth development framework: Implications for community prevention. Children and Youth Services Review, 31:1001-1009.
- Roothman, B., Kirsten, D. & Wissing, M. 2003. Gender differences in aspects of psychological wellbeing. South African Journal of Psychology, 33(4):212-218.
- Rose, S.B., Cooper, A.J., Baker, N.K. & Lawton, B. 2011. Attitudes toward long-acting reversible contraception among young women seeking abortion. Journal of Women's Health, 20(11):1729-1735.
- Rosen, B.L. 2010. The attitudes, perceptions and experiences of college students regarding sexual health issues. Unpublished Thesis. Texas, Texas State University.
- Rosenberg, L. 2008. To preserve, strengthen and expand America's mental health and addictions treatment capacity. Journal of Behavioural Health Services and Research, 35(3):237-239.
- Rosenberg, M. 1965. Society and adolescent self-image. Princeton, NJ: Princeton University Press.
- Rossman, G.B. & Rallis, S.F. 2012. Learning in the field: An introduction to Qualitative Research. London: SAGE.

- Rowlands, S. (Ed.) 2014. Abortion Care. UK: Cambridge University Press.
- Rubin, A. & Babbie, E. 2013. Essential research methods for social work. Australia: Brooks/Cole Cengage Learning.
- Rubin, A. & Babbie, E.R. 1993. Research Methods for Social Work. 2nd Edition. Pacific Grove, CA: Brooks/Cole.
- Rule, S. 2004. Rights or wrongs? Public attitudes toward moral values. Human Sciences Research Council Review, 2(3):4-5.
- Russo, N.F., Horn, J.D. & Schwartz, R. 1992. Abortion in context: selected characteristics and motivations of women seeking abortion. Journal of Social Issues, 48(3):183-202.
- Russo-Gleicher, R.J. 2013. Qualitative insights into faculty use of student support services with online students at risk: Implications for student retention. Journal of Educators Online, 10(1). [Online]. Available: <https://eric.ed.gov/?id=EJ1004894> [Accessed: 12/02/2015].
- SAACHDE. 2010. Current themes in therapy with students in higher education as found at TUT, and its relation to Eriksonian Developmental Theory – alignments and anomalies. Unpublished paper presented by Ms E.S. de la Rey. Annual National Conference of The Southern African Association for Counseling and Development in Higher Education (SAACHDE), 13-16 September, Stellenbosch University.
- SACSSP. n.d. Professional Conduct & Ethics. [Online]. Available: <https://www.sacssp.co.za/Conduct> [Accessed: 09/11/2009 & 30/11/2011].
- Saddock, B.J. & Saddock, V.A. 2003. Synopsis of Psychiatry. 9th Edition. Philadelphia, PA: Lippincot, Williams & Williams.
- Sadler, L.S., Swartz, M.K., Ryan-Krause, P., Seitz, V., Meadows-Olivier, M., Grey, M. & Clemmens, D.A. 2007. Promising outcomes in teen mothers enrolled in a school based parent support program and childcare center. Journal of School Health, 77(3):121-130.
- Sahar, G. & Karasawa, K. 2005. Is the personal always political? A cross-cultural analysis of abortion attitudes. Basic and Applied Social Psychology, 27:285-296.
- Sandelowski, M. 1999. Focus on qualitative methods: time and qualitative research. Research in Nursing and Health, 22:79-87.

- Santelli, J.S., Orr, M., Lindberg, L.D. & Diaz, D.C. 2009. Changing behavioral risk for pregnancy among high school students in the United States, 1991 – 2007. Journal of Adolescent Health, 45:25-32.
- Santrock, J. 1998. Adolescence. 7th Edition. Boston, MA: McGraw-Hill.
- Schärwachter, P. 2008. Abortion decision making by focusing: A preliminary study. The European Journal of Contraception and Reproductive Health Care, 13(2):191-197.
- Schenck, R., Roman, N., Erasmus, C., Blaauw, D. & Ryan, J. 2017. Homeless in Observatory, Cape Town, through the lens of Max-Neef's fundamental human needs taxonomy. Social Work, 53(2):266-287.
- Schleicher, H.E., Harris, K.J., Catley, D. & Nazir, N. 2009. The role of depression and negative affect regulation expectancies in tobacco smoking among college students. Journal of American College Health, 57(5):507-512.
- Schlossberg, N.K. 1981. A model for analyzing human adaptation to transition. The Counselling Psychologist, 9(2):2-18.
- Schlossberg, N.K. 1984. Counselling adults in transition. New York, NY: Springer.
- Schlossberg, N.K. 2011. The challenge of change: the transition model and its applications. Journal of Employment Counselling, 48:159-163.
- Schlossberg, N.K., Lynch, A.Q. & Chickering, A.E. 1989. Improving Higher Education Environments for Adults. San Fransisco, CA: Jossey-Bass.
- Schnyder, U., Ehlers, A., Elbert, T., Foa, E.B., Gersons, B.P.R., Resick, P.A., Shapiro, F. & Cloitre, M. 2015. Psychotherapies for PTSD: what do they have in common? European journal of Psychotraumatology, 6:10. [Online]. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4541077/> [Accessed: 16/11/2018].
- Schurink, W., Fouché, C.B. & De Vos, A.S. 2011. Qualitative data analysis and interpretation. In: De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.I. Research at grass roots: a primer for the caring professions. 4th Edition. Pretoria: Van Schaik: 397-423.
- Section27. 2016. Basic Education Rights Handbook. [Online]. Available: www.section27.org.za/basic-education-handbook [Accessed: 29/11/2016].
- Sedgh, G., Henshaw, S., Singh, S., Ahman, E. & Shah, I. 2007. Induced abortion: estimated rates and trends worldwide. The Lancet, 370:1338-1345.

- Sekgobela, C. B. 2008. Pregnancy- related challenges encountered by student nurses at the South African military health services nursing college. M.A. dissertation in Public Health. Pretoria, University of South Africa.
- Sekudu, J. 2001. Abortion as social work study. DPhil dissertation in Social Work. Pretoria, University of Pretoria.
- Sereno, S., Leal, I. & Maroco, J. 2013. The role of psychological adjustment in the decision-making process for voluntary termination of pregnancy. Journal of Reproduction and Infertility, 14(3):143-151.
- Seutlwadi, L., Peltzer, K & Mchunu, G. 2012. Contraceptive use and associated factors among South African youth (18-24 years): A population based survey. South African Journal of Obstetrics and Gynaecology, 8(2):43-47.
- Sewell, M. n.d. The use of qualitative interviews in evaluation. [Online]. Available: <http://ag.arizona.edu/sfcs/cyfernet/cyfar/Intervu5.html> [Accessed: 04/11/2009].
- Shahry, P., Kalhori, S.R.N., Esfandiyari, A. & Zamani-Alavijeh, F. 2016. A comparative study of perceived social support and self-efficacy among women with wanted and unwanted pregnancy. International Journal of Community Based Nursing and Midwifery, 4(2):176-185. [Online]. Available: <https://www.ncbi.nlm.nih.gov/pubmed/27218115> [Accessed: 16/02/2016].
- Sharma, B. 2012. Adjustment and emotional maturity among first year college students. Pakistan Journal of Social and Clinical Psychology, 9:32-37.
- Shaw, I. & Gould, N. 2001. Qualitative Research in Social Work. Thousand Oaks, CA: SAGE.
- Shaw, M., Lawlor, D.A. & Najman, J.M. 2006. Teenage children of teenage mothers: psychological, behavioural and health outcomes from an Australian perspective longitudinal study. Social Science and Medicine, 62:2526-2539.
- Shenton, A.K. 2004. Strategies for ensuring trustworthiness in qualitative research projects. Evaluation for Information, 22:63-75.
- Sieving, R.E., Eisenberg, M.E., Pettingell, S. & Skay, C. 2006. Friends' influence of adolescents' first sexual intercourse. Perspectives on Sexual and Reproductive Health, 38:13-19.

- Sigelman, C.K. & Ryder, E.A. 2006. Life-span human development. 5th Edition. Belmont, CA: Thomson Wadworth.
- Silverman, D. 2005. Doing Qualitative Research. London: SAGE.
- Silverman, D. 2010. Doing Qualitative Research. 3rd Edition. Thousand Oaks, CA: SAGE.
- Singh, S. & Darroch, J.E. 2000. Adolescent pregnancy and childbearing: Levels and trends in developed countries. Family Planning Perspectives, 32(1):14-23.
- Singleton, K. & Krause, E.M.S. 2009. Understanding cultural and linguistic barriers to health literacy. The Online Journal of Issues in Nursing, 14(3). [Online]. Available: <http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol142009/No3Sept09/Cultural-and-Linguistic-Barriers-.html> [Accessed: 17/01/2014].
- Skinner, S.R., Smith, J., Fenwick, J., Hendriks, J., Fyfe, S. & Kendall, G. 2009. Pregnancy and protection: Perceptions, attitudes and experiences of Australian female adolescents. Women and Birth, 22:50-56.
- Smith, C., Ly, S., Uk, V., Warnock, R. & Free, C. 2017. Women's views and experiences of a mobile phone-based intervention to support post-abortion contraception in Cambodia. Reproductive Health, 14:72-82.
- Smith, P.J. 2006. Study Shows Abortion Takes Toll on Adolescent Mental Health. [Online]. Available: <https://www.lifesitenews.com/news/study-shows-abortion-takes-toll-on-adolescent-mental-health> [Accessed: 01/10/2009].
- Smith, W., Turan, J.M., White, K., Stringer, K.L., Helova, A., Simpson, T. & Cockrill, K. 2016. Social norms and stigma regarding unintended pregnancy and pregnancy decisions: A qualitative study of young women in Alabama. Perspectives on Sexual and Reproductive Health, 48(2):73-81.
- SmithBattle, L. 2007. "I wanna have a good future": Teen mothers' rise in educational aspirations, competing demands and limited school support. Youth and Society, 38(3):348-371.
- Sneed, J.R., Whitbourne, S.K. & Culang, M.E. 2006. Trust, Identity and Ego Integrity: Modeling Erikson's core stages over 34 years. Journal of Adult Development, 13:148-157.

- Snow, M.S., Wolff, L., Hudspeth, E.F. & Etheridge, L. 2009. The practitioner as a researcher: Qualitative case studies in play therapy. International Journal of Play Therapy, 8(4):240-250.
- Soanes, C., Spooner, A. & Hawker, S. 2001. Oxford paperback Dictionary Thesaurus & Wordpower Guide. New York, NY: Oxford University Press.
- Sodi, E.E. 2009. Psychological impact of teenage pregnancy on pregnant teenagers. M.A. dissertation in Clinical Psychology. Polokwane: University of Limpopo.
- South Africa. 1975. The Abortion and Sterilisation Act (Act No 2) of 1975. Government Gazette, 117(4608). Pretoria: Government Printer.
- South Africa. 1978. The Social Service Professions Act (Act No 110) of 1978 (as amended). Government Gazette, 632(41418). Pretoria: Government Printer.
- South Africa. 1996. Choice on Termination of Pregnancy Act (Act No 92) of 1996. Government Gazette, 377(17602). Pretoria: Government Printer.
- South Africa. 2001. Higher Education Amendment Act (Act No 23) of 2001. Government Gazette, 1104(22808). Pretoria: Government Printer.
- South Africa. 2005. Choice on Termination of Pregnancy Amendment Act (Act No 38) of 2004. Government Gazette, 476(27267). Pretoria: Government Printer.
- South Africa. 2015. National Youth Policy 2015 – 2020. [Online]. Available: <https://www.gov.za/documents/national-youth-policy-2015-2020-8-jun-2015-0000> [Accessed: 12/02/2017].
- South Africa. Department of Welfare. 1997. White Paper for Social Welfare: principles, guidelines, recommendations, proposed policies and programmes for developmental social welfare in South Africa. (Government Notice R1108 of 1997.) Government Gazette, 386(18166), 8 Aug:3-100.
- Speckhard, A.C. & Rue, V.M. 1992. Post-abortion syndrome: an emerging public health concern. Journal of Social Issues, 48(3):95-119.
- Sriranganathan, G., Jaworsky, D., Larkin, J., Flicker, S., Campbell, L., Flynn, S., Janssen, J., & Erlich, L. 2010. Peer sexual health education: Interventions for effective program evaluation. Health Education Journal, 71(1):62-71.

- Stack, R.J. & Meredith, A. 2018. The Impact of Financial Hardship on Single Parents: An Exploration of the Journey From Social Distress to Seeking Help. Journal of Family and Economic Issues, 39(2):233-242.
- Stake, R.E. 2005. Qualitative case studies. In: Denzin, N.K. & Lincoln, Y.S. (Eds). The Sage Handbook of Qualitative Research. 3rd Edition. Thousand Oaks, CA: SAGE 443-466.
- Statistics South Africa. 2008. *Statistical Release Community Survey 2007*. Pretoria: Statistics South Africa.
- Statistics South Africa. n.d. South Africa Demographic and Health Survey 2016. [Online]. Available: http://www.statssa.gov.za/?page_id=6634 [Accessed: 05/03/2017].
- Steck, A.M. 2011. Assisting a Northern California Crisis Pregnancy Center meet the needs of its clientele: A proposal for change. M.A. dissertation in Social Sciences. Long Beach, CA, California State University.
- Steinberg, J.R. & Russo, N.F. 2008. Abortion and anxiety: what's the relationship? Social Science & Medicine, 67(2):238-252.
- Steinberg, J.R. & Russo, N.F. 2009. Evaluating research on abortion and mental health. Contraception, 80(2009):500-203.
- Steinberg, J.R. & Russo, N.F. 2009. Evaluating research on abortion and mental health. Contraception, 80(2009):500-203.
- Stets, J.E. & Burke, P.J. 2014. Self-Esteem and Identities. Sociological Perspectives, 57(4):409-433.
- Stewart, H., McCall, S.J., McPherson, C., Towers, L.C., Lloyd, B., Fletcher, J. & Bhattacharya, S. 2016. Effectiveness of peri-abortion counselling in preventing subsequent unplanned pregnancies: A systematic review of randomized controlled trials. Journal for Family Planning and Reproductive Health, 42:59-67.
- Story, W.A. 1999. The effects of unplanned pregnancies among college women. M.A. thesis in Educational Leadership and Policy Studies. Virginia, Virginia Polytechnic Institute and State University.
- Stoyles, B.J. 2015. The value of pregnancy and the meaning of pregnancy loss. Journal of Social Philosophy, 46(1):91-105.

- Streubert-Speziale, H.J. & Carpenter, D.R. 2007. Qualitative research in nursing: Advancing the humanistic imperative. 4th Edition. Philadelphia, PA: Lippincot.
- Stuart, G.S. 2009. Fourteen million women with limited options: HIV / AIDS and highly effective reversible contraception in sub-Saharan Africa. Contraception, 80:412 – 416.
- Student Counsellor, Tertiary Institution B, Pretoria. 2009. Telephone interview. 10 November. Pretoria.
- Student Counsellor, Tertiary Institution C, Pretoria. 2009. Personal interview. 3 November. Pretoria.
- Student Counsellor, Tertiary Institution D, Pretoria. 2009. Personal interview. 21 October. Pretoria.
- Student Counsellors, Tertiary Institution D, Pretoria. 2009. Round table discussion. 21 October. Pretoria.
- Student Counsellors, Tertiary Institution D, Pretoria. 2014. Round table discussion. 4 April. Pretoria.
- Suri, H. 2011. Purposeful sampling in qualitative research synthesis. Qualitative Research Journal, 11(2):63-75.
- Svanemyr, J., Amin, A., Robles, O. & Greene, M.E. 2015. Creating an enabling environment for adolescent sexual and reproductive health: A framework and promising approaches. Journal of Adolescent Health, 56:7-14.
- Swanson, R.A. & Chermack, T.J. 2013. Theory Building in Applied Disciplines. San Francisco, CA: Berrett-Koehler.
- Tabane, N.S. & Mmapheko, D.P. 2015. Perceptions of female teenagers in the Tshwane District on the use of contraceptives in South Africa. Curationis, 38(2):1-7. [Online]. Available: <http://www.curationis.org.za/index.php/curationis/article/view/1528> [Accessed: 18/01/2016].
- Tach, L., Mincy, R. & Edin, K. 2010. Parenting as a package deal: Relationships, fertility and non-resident father involvement among young unmarried parents. Demography, 47(1):181-204.
- Terre Blanche, M., Durrheim, K. & Painter, D. 2006. Research in practice: Applied methods for the social sciences. Cape Town: University of Cape Town Press.

- Tertiary Institution D. 2012. Residence Rules and Regulations. Pretoria: Tertiary Institution D.
- Tertiary Institution D. 2015. Residence Rules and Regulations. Pretoria: Tertiary Institution D.
- Tesch, R. 1990. Qualitative Research: Analysis types and software tools. New York, NY: RoutledgeFalmer.
- The Director, Crisis Pregnancy Care Centre, Pretoria. 2009. Personal Interview, 26 October 26 & 9 November. Pretoria⁵¹.
- The Director, Crisis Pregnancy Care Centre, Pretoria. 2014. Personal Interview, 22 August. Pretoria.
- The National Campaign. 2009. Unplanned Pregnancy and Community Colleges. [Online]. Available:
<http://www.cctech.edu/documents/unplannedpregnancyandcommunitycolleges.pdf>
 [Accessed: 17/06/2015].
- Thomas, A. 2012. Policy Solutions for Preventing Unplanned Pregnancy. [Online]. Available: <http://www.brookings.edu/research/reports/2012/03/unplanned-pregnancy-thomas> [Accessed: 11/12/2012].
- Thomas, E. & Magilvy, J.K. 2011. Qualitative rigor research validity in qualitative research. Journal for Specialists in Paediatric Nursing, 16:151-155.
- Thomas, G. 2016. How to do your case study. 2nd Edition. London: SAGE.
- Thomas, G. 2017. How to do your research project: A guide for students. 3rd Edition. London: SAGE.
- Thompson, J. 2005. "The Journey: a road to post-abortion recovery". A Volunteer Training Manual. Pretoria: Crisis Pregnancy Care Centre.
- Thompson, N. & Thompson, S. 2016. The Social Work Companion. New York, NY: Palgrave.
- Tladi, F.M. & Jali, N.M. 2014. Factors contributing to pregnancy amongst female students at the University of Limpopo, Turfloop campus, South Africa. African Journal for Physical, Health Education, Recreation and Dance (AJPHERD), 1(2):275-283.

⁵¹ Please note that the name of the Director as well as the name of the CPCC is withheld in order to protect their identity and to maintain confidentiality and anonymity.

- Tol, W.A., Barbui, C., Galappatti, A., Silove, D., Betancourt, T.S., Souza, R., Golaz, A. & Van Ommeren, M. 2011. Mental health and psychosocial support in humanitarian settings: linking practice and research. The Lancet, 378(9802):1581-1591. [Online]. Available: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(11\)61094-5/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61094-5/fulltext) [Accessed: 13/04/2016].
- Tomoda, A., Mori, K., Kimura, M., Takahashi, T. & Kitamura, T. 2000. One-year prevalence and incidence of depression among first year university students in Japan: A preliminary study. Psychiatry and Clinical Neurosciences, 54:583-588.
- Tran, L. & Rimes, K.A. 2017. Unhealthy perfectionism, negative beliefs about emotions, emotional suppression, and depression in students: A mediational analysis. Personality and Individual Differences, 110:144-147.
- Transitions Through Life. n.d. Full Biography. [Online]. Available: <https://www.transitionsthroughlife.com/bio/full-biography/> [Accessed 18/06/2016].
- Trueman, K.A. & Magwentshu, M. 2013. Abortion in a progressive legal environment: The need for vigilance in protecting and promoting access to safe abortion services in South Africa. American Journal of Public Health, 103(3):397-399.
- Trybulski, J. 2006. Women and abortion: the past reaches into the present. Issues and Innovations in Nursing Practice, 54(6): 683-690.
- Tsilo, M.M. 2007. Exploring the psychological sequelae of women who have undergone abortion: A multiple case-study approach. Unpublished dissertation in Clinical and Community Counselling Psychology. Stellenbosch, Stellenbosch University.
- Tufford, L. & Newman, P. 2012. Bracketing in Qualitative Research. Qualitative Social Work, 11(1):80-96.
- Turner, F.J. 2011. Social Work Treatment, Interlocking Theoretical Approaches. 5th Edition. New York, NY: Oxford University Press.
- United Nations. 2011. World Population Prospects: The 2010 Revision. [Online]. Available: http://www.un.org/en/development/desa/population/publications/pdf/trends/WPP2010/WPP2010_Volume-I_Comprehensive-Tables.pdf [Accessed: 16/02/2012 & 14/06/2016].
- Upadhyia, K.K. & Ellen, J.M. 2011. Social disadvantage as a risk for first pregnancy among adolescent females in the United States. Journal of Adolescent Health, 49:538-541.

- Usher, K. & Jackson, D. 2014. Phenomenology. In: Mills, J. & Birks, M. (Eds). Qualitative methodology: A practical guide. London: SAGE.
- Valois, R.F, Zullig, K.J, Kammermann, S.K & Kershner, S. 2013. Relationships between Adolescent Sexual Risk Behaviours and Emotional Self-Efficacy. American Journal of Sexuality Education, 8(1-2):36-55.
- Van Breda, A.D. 2011. University of Johannesburg Social Work Students' Experiences of Life Challenges. Johannesburg: University of Johannesburg.
- Van den Bos, G.R. 2007. APA Dictionary of Psychology. Washington, DC: American Psychological Association.
- Van der Westhuizen, M.A. 2010. Aftercare to chemically addicted adolescents: Practice guidelines from a social work perspective. DPhil dissertation in Social Work. Pretoria, University of South Africa.
- Varcarolis, E.M. 2006. Developing therapeutic relationships. In: E.M. Varcarolis (Ed.) Nursing Tools, unit 3. [Online]. Available: https://www.ohsu.edu/xd/outreach/occysn/training-education/upload/developingtheraputicrelationships_ch10.pdf [Accessed: 12/03/2018].
- Varga, C.A. 2003. How gender roles influence sexual and reproductive health among South African Adolescents. Studies in Family Planning, 34:160-172.
- Vorkapić, S.T. & Mustapić, J. 2012. Internal and external factors in professional burnout of substance abuse counselors in Croatia. Scientific Electronic Library Online, 48(2):189-190. [Online]. Available: <https://www.scielo.org/pdf/aiss/2012.v48n2/189-197/en> [Accessed: 16/02/2016].
- Wahyuni, D. 2012. The Research Design Maze: Understanding paradigms, cases, methods and methodologies. Journal of Applied Management Accounting Research, 10(1):69-80.
- Walkner, A. J., & Rueter, M. A. 2014. Adoption Status and Family Relationships During the Transition to Young Adulthood. Journal of Family Psychology, 28(6):877–886.
- Warren, J.T., Harvey, S.M. & Henderson, J.T. 2010. Do depression and low self-esteem follow abortion among adolescents? Evidence from a national study. Perspectives on Sexual and Reproductive Health, 42(4):230-235.

- Wechsberg, W.M., Luseno, W., Riehman, K., Karg, R., Browne, F. & Parry, C. 2009. Substance Use and Sexual Risk Within the Context of Gender Inequality in South Africa. Substance Use & Misuse, 43(8-9):1186-1201. [Online]. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3129982/> [Accessed: 20/03/2016].
- Wekesa, E. 2016. Contraception and unintended pregnancy: The changing relationship over time in sub-Saharan Africa. African Population Studies, 30(2):2777-2786.
- Wellings, K., Jones, K.G., Mercer, C.H., Tanton, C., Clifton, S., Datta, J., Copas, B.E., Gibson, L.J., Macdowall, W., Sonnenberg, P., Phelps, A. & Johnson, A.M. 2013. The Prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). The Lancet, 382(9907):1807-1816.
- Welman, C., Kruger, F. & Mitchell, B. 2005. Research Methodology. 3rd Edition. Cape Town: Oxford University Press.
- Wheeler, S.B., Zullig, L.L., Reeve, B.B., Buga, G.A. & Morroni, C. 2012. Attitudes and Intentions Regarding Abortion Provision Among Medical School Students in South Africa. International Perspectives on Sexual and Reproductive Health, 38(3):154-163.
- White Paper for Social Welfare, see South Africa. Department of Welfare. 1997.
- Whittaker, A. 2012. Research Skills for Social Work. Los Angeles, CA: SAGE.
- Wiebe, E.R., Littman, L., Kaczorowski, J. & Moshier, E.L. 2014. Misperceptions about the risks of abortion in women presenting for abortion. Journal of Obstetrics and Gynaecology Canada, 36(3):223-230.
- Wiemann, C.M., Rickert, V.I., Berenson, A.B. & Volk, R.J. 2005. Are pregnant adolescents stigmatized by pregnancy. Journal of Adolescent Health, 36: 352-387.
- Wilks, S.E. & Spivey, C.A. 2010. Resilience in undergraduate social work students: Social support and adjustment to academic stress. Social work Education: The International Journal, 29:276-288.
- Wilks, S.E. 2008. Resilience amid academic stress: The moderating impact of social support among social work students. Advances in Social Work, 9:106-125.

- Wise, A., Geronimus, A.T. & Smock, P.J. 2017. The best of intentions: A structural analysis of the association between socioeconomic disadvantage and unintended pregnancy in a sample of mothers from the National Longitudinal Survey of Youth (1979). Women's Health Issues, 27(1):5-13.
- Wits Reproductive Health and HIV Institute. 2014. Home Page. [Online]. Available: www.wrhi.ac.za [Accessed: 01/02/2014].
- Wood, K. & Jewkes, R. 2006. Blood blockages and scolding nurses: barriers to adolescent contraceptive use in South Africa. Reproductive Health Matters, 14:109-118.
- Wood, K., Maforah, F. & Jewkes, R. 1998. "He forced me to love him": putting violence on adolescent sexual health agendas. Social Science & Medicine, 47(2):233-242.
- Workman, J.L. 2015. Exploratory students' experiences with first-year academic advising. NACADA Journal, 35(1):5-12.
- World Health Organization. 1999. *Partners in Life Skills Education*. [Online]. Available: https://www.who.int/mental_health/media/en/30.pdf [Accessed: 11/12/2013].
- World Health Organization. 2009. World Health Statistics 2009. [Online]. Available: https://www.who.int/gho/publications/world_health_statistics/2009/en/ [Accessed: 11/12/2013].
- World Health Organization. 2011. Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes among Adolescents in Developing Countries. Geneva: WHO.
- World Health Organization. 2012. Safe abortion: technical and policy guidance for health systems. Geneva: WHO.
- World Health Organization. 2015. World Health Statistics 2015. Geneva: WHO.
- Wu, Y.P., Thompson, D., Aroian, K.J., McQuaid E.L. & Deatrck, J.A. 2016. Commentary: Writing and Evaluating Qualitative Research Reports. Journal of Pediatric Psychology, 41(5):493–505.
- Yankey, T. & Biswas, U.N. 2012. Life Skills Training as an Effective Intervention Strategy to Reduce Stress among Tibetan Refugee Adolescents. Journal of Refugee Studies, 25(4):514-536.
- Yates, J. & Leggett, T. 2016. Qualitative Research: An introduction. Radiologic Technology, 88(2):225-231.

- Yilmaz, K. 2013. Comparison of quantitative and qualitative research traditions: epistemological, theoretical, and methodological differences. European Journal of Education, 48(2):311-325.
- Yin, R.K. 2011. Qualitative research from start to finish. New York, NY: The Guilford Press.
- Yunos, H. 2010. Perceptions of students at the University of KwaZulu-Natal, South Africa, regarding factors influencing high fertility rates among young people. M.A. dissertation in Population Studies. Durban, University of KwaZulu-Natal.
- Zachry, E.M. 2005. Getting my education: Teen mothers' experiences in school before and after motherhood. Teachers College Record, 107(12):2566-2598.
- Zastrow, C.H. 2010. The Practice of Social Work – A comprehensive work text. 9th Edition. USA: Brooks/Cole Publishing Company.



DATE

The Dean/HOD/Director
University/Organisation
Department/Faculty

Dear Prof/Dr/Mr./Ms _____

Regarding: Request for permission to conduct research

I am a social worker employed at a tertiary institution⁵² in Tshwane (Pretoria), Gauteng, and also a doctorate student in the Department of Social Work at the University of South Africa (UNISA). In fulfillment of the requirements for this degree, I have to undertake a research project and have consequently decided to focus on the following research topic:

“Tertiary students’ experiences and needs related to unplanned pregnancy and the termination of pregnancy (TOP): Practice guidelines for psychosocial support”.

This research project originated as a result of concern about the significant increase in unplanned pregnancies and the termination of pregnancies amongst students at tertiary institutions – these phenomena have become a national and international concern and it poses a multiplicity of problems for students and academic institutions: It accounts for a high dropout rate that results in serious financial costs incurred by the institution, the

⁵² The name of the institution is withheld for the purpose of honoring and maintaining anonymity and confidentiality and the institution/my place of employ is consequently referred to as *Tertiary Institution D*.

student and her family and it has also been identified as one of the factors affecting the throughput targets of tertiary institutions. An unintended pregnancy at tertiary level is generally perceived as a crisis: The emotional impact of the crisis pregnancy, which often results in the termination of the pregnancy (TOP), furthermore has a detrimental effect on the student's well-being, relationships and ultimately also her academic performance.

There is pressure on tertiary institutions to address high student dropout rates and increase their throughput rates. Universities are encouraged to not only investigate this problem, but also design intervention strategies whereby it could be addressed effectively.

The purpose of my research is therefore to formulate guidelines for psychosocial support, from the ambit of social work, directed at service providers to respond to the psychosocial needs of tertiary students who had an unplanned pregnancy and/or terminated an unplanned pregnancy. Mentioned guidelines are to be informed by and based on the experiences, needs of tertiary students presenting with an unplanned pregnancy and/or TOP as well as their suggestions for psychosocial support to students presenting with this phenomena. The guidelines are also to be informed by the perceptions of service providers rendering psychosocial support services to tertiary students presenting with an unplanned pregnancy and/or TOP about the experiences and support needs of these students; the scopes of the support services offered to them and their suggestions for psychosocial support to said students.

The target populations selected for this study, as well as the inclusion criteria, is as follows:

1. Tertiary students, enrolled at one of four of Gauteng's tertiary institutions, who had experienced an unplanned pregnancy and/or a TOP

Criteria of inclusion: Students-

- both day- and residence students
 - of all ages and race groups
 - enrolled at any of the four participating tertiary institutions in the Gauteng province
 - who had made an appointment with, or requested support/assistance from a service provider in relation to an unplanned pregnancy and/or a TOP.
2. Service providers - volunteer counsellors, healthcare professionals, social workers and psychologists rendering support services to students with unplanned pregnancies and/or TOP's at these tertiary institutions in Gauteng

Criteria of inclusion: Service providers with reference to –

- Social workers, psychologists and healthcare professionals employed at any of the four participating tertiary institutions in Gauteng, rendering support services to tertiary students with unplanned pregnancies and/or students who have terminated their pregnancies
- Volunteer counsellors at the satellite office of a crisis pregnancy care centre (CPCC) that was established on one of the campuses of one of the participating tertiary institutions, who renders support services to tertiary students with unplanned pregnancies and/or students who have terminated their pregnancies
- Volunteer counsellors at the head office of said CPCC in Pretoria (Tshwane), who renders support services to tertiary students with unplanned pregnancies and/or students who have terminated their pregnancies.

Above mentioned populations and institutions were chosen for inclusion in this study because of their experience, knowledge and skills, which is particularly relevant, practical and applicable to this study: It will give me insight in and a better understanding of the phenomena, which will assist me with formulating the guidelines for psychosocial support.

Should permission for conducting this research at your institution/organisation be granted, I intend to arrange a meeting with the service providers at your setting where the following will be discussed and explained:

- The service providers will be requested identify gatekeepers or to act as gatekeepers, identifying and regulating access to the client system group (tertiary students with unplanned pregnancies and/or students who have terminated their pregnancies)
- The service providers will be invited to also participate in the research study
- The purpose of the study, method of data collection, namely, focus group discussions with the service providers and in-depth, semi-structured face-to-face interviews with the tertiary students; practical arrangements regarding data collection, voluntary participation, anonymity and confidentiality and informed consent.

Once the willingness of the participants to partake has been established, arrangements will be made for the data collection: This will be done with respect and consideration for the schedules and commitments of the participants – I will conduct the data collection at times and locations which will be convenient for the participants. I furthermore intend to disseminate the results of this study to the participating service providers by means of a written report.

Kindly note that this study has been approved by the Research and Ethics Committee (DR&EC) of the Department of Social Work at UNISA, as well as the Research Ethics

Committee of the institution where I am employed (referred to *Tertiary Institution D* for the purpose of maintaining anonymity and confidentiality). Should you have any questions not sufficiently answered by me as the researcher, you may contact the Chairpersons of these Committees:

UNISA: Prof A.H Alpaslan
Telephone number: 012 429 6739
E-mail: alpash@unisa.ac.za

Tertiary Institution D: Please contact me and I will direct your enquiry to the Chairperson of this institution's Research Ethics Committee.

Your consideration of my request is highly appreciated. Please don't hesitate to contact me, should you have any further queries.

Kind regards,

Lynette Conradie

Tel: 083 776 3989

E-mail: conradiel2018@gmail.com



Invitation to participate in a research study

Tertiary students, enrolled at one of four tertiary institutions in Gauteng, who had experienced an unplanned pregnancy and/or termination of pregnancy (TOP)

Research Topic:

“Tertiary students’ experiences and needs related to unplanned pregnancy and the termination of pregnancy (TOP): Practice guidelines for psychosocial support”.

Researcher: Lynette Conradie: M.A Soc.Sci (Clinical)

Research promoter: Prof A.H. Alpaslan: Department of Social Work, UNISA

Dear research participant

I am a social worker employed at a tertiary institution in Pretoria (Tshwane)⁵³, Gauteng, and also a doctorate student in the Department of Social Work at the University of South Africa (UNISA). In fulfillment of the requirements for this degree, I have to undertake a research project. In view of the fact that you are well informed about the topic, I hereby approach you with an invitation to participate in this research study.

⁵³ The name of the institution is withheld for the purpose of honoring and maintaining anonymity and confidentiality and the institution/my place of employ is consequently referred to as *Tertiary Institution D*.

This invitation contains information regarding the study: Please read it, as it will assist you in your decision whether to participate in the study. It is important that you ensure that you fully understand what is involved in the study and that you are satisfied with all aspects of it, before you agree to participate.

THE PURPOSE OF THE STUDY

This research project originated as a result of concern about the prevalence of and increase in unintended pregnancy and the termination of pregnancy (TOP) amongst tertiary students. An unmarried student at a tertiary institution, experiencing an unplanned pregnancy, usually finds herself in the midst of a multifaceted crisis for which she has to find a solution as soon as possible. None of the available options, namely parenting, adoption or termination of the pregnancy (TOP), is easy and usually has far-reaching implications for the student, her significant others as well as the tertiary institution. There furthermore seems to be a lack of guidelines, strategies or programmes to support tertiary students reporting for support and assistance with unplanned pregnancies and/or TOPs.

The purpose of my research is therefore to formulate guidelines for psychosocial support, from the ambit of social work, directed at service providers to respond to the psychosocial needs of tertiary students who had an unplanned pregnancy and/or terminated an unplanned pregnancy. Mentioned guidelines are to be informed by and based on the experiences, needs of tertiary students presenting with an unplanned pregnancy and/or TOP as well as their suggestions for psychosocial support to students presenting with this phenomena. The guidelines are also to be informed by the perceptions of service providers rendering psychosocial support services to tertiary students presenting with an unplanned pregnancy and/or TOP about the experiences and support needs of these students; the scopes of the support services offered to them and their suggestions for psychosocial support to said students.

CRITERIA FOR INCLUSION

You are invited to participate in this research study because you are a tertiary student who have experienced an unplanned pregnancy and/or TOP and therefore have knowledge about the experiences and support needs of tertiary students confronted with this phenomenon. You are able to reflect on the occurrence of your unplanned pregnancy, the outcome thereof and in particular the support, or lack thereof, that you received during this experience. You furthermore meet the inclusion criteria for this study, namely:

- You are enrolled at one of four participating institutions of higher education in Gauteng
- You have made an appointment with or requested support/assistance⁵⁴ from a service provider in relation to your unplanned pregnancy and/or TOP

WHAT WILL BE REQUIRED FROM YOU?

If you decide to participate in the study, you will be required to do the following:

- Leave your telephone number on the declaration sheet at the end of this invitation and sign the declaration, indicating that you have read the information and that I may contact you to confirm your interest in and willingness to participate in this study and to make arrangements for conducting the research. You can leave your declaration form with the service provider who gave you this invitation.

⁵⁴ Please note that the support services that you requested/are utilising will remain confidential and will not be compromised or influenced in any way whatsoever, should you decide to not participate in this study.

- I will call you and make an appointment for a meeting with you at a time and place that would be convenient for you. The following will happen during this meeting:
 1. You will have the opportunity to ask any questions you might have regarding the study.
 2. You will be requested to sign an informed consent form.
 3. I will conduct an in-depth, semi-structured face-to-face interview with you. This interview will take place in a comfortable, safe environment where there will be adhered to the principles of privacy and confidentiality. The following requests and questions will be directed at you during this interview:

Biographical questions:

- *How old are you?*
- *What course of study are you enrolled for?*
- *For which year of study are you currently registered?*
- *Where are you residing (I.e. University accommodation such as a residence or commune; or private accommodation such as a flat)?*
- *In which province do you live when not at university?*
- *How would you describe the area you grew up in (I.e. Urban, semi urban, rural)*

Questions pertaining to the topic under investigation:

Opening request: *Can you please describe to me, in as detailed a manner as possible, your situation when you experienced your unplanned pregnancy?*

Further probing requests and questions:

- *What would you say were the reasons for your unplanned pregnancy?*

- *Share with me what your personal circumstances were at the time of your unplanned pregnancy?*
- *Think back and share with me the feelings/emotions that you experienced when you realised that you were pregnant?*

Follow-up central request 1: *Please share with me how the unplanned pregnancy that you had experienced changed your life.*

Follow-up central request 2: *Share with me how you dealt with your unplanned pregnancy...*

Further probing requests and questions in response to the second follow-up central request::

- *Tell me about the factors that influenced the decision that you have taken in order to deal with your unplanned pregnancy...*
- *What feelings/emotions did you experience as a result of your decision taken to deal with your unplanned pregnancy?*

Follow up central request 3: *Please tell me about the types of support that you received in relation to your UP and/or TOP?*

a)... on campus...

b)... off campus ...

Further requests and probing questions:

- *Share with me how you experienced the support that you received*
- *Looking back on the support that you received, what would you have liked to be different in terms thereof?*

Follow up central request 4: *Based on your experience as a tertiary student who had an UP and/or a TOP, what suggestion(s) do you have on how students who present with an UP and/or TOP could/should be supported ...*

At the end of the interview, you will be invited to write a letter, which you can submit within one month after the interview. This will give you an opportunity to share, add or reflect on any other, additional information with regard to your experience and/or needs related to your unplanned pregnancy and/or TOP.

- Be assured that your opinion and views will be respected and appreciated and that it will make a valuable contribution to this research study.
- It is estimated that this meeting will last approximately 90 minutes.

YOUR RIGHTS AS A PARTICIPANT IN THIS STUDY

Your participation in this research study is entirely voluntary and you have the right to withdraw at any time, without needing to give a reason for your decision. Your decision to participate, or not, will not impact on any of the services offered to you by any of the service providers or support units utilised by you.

POSSIBLE EFFECTS OF THE STUDY ON YOU AS A PARTICIPANT

Due to the personal nature of the interview questions, you could possibly experience some emotional discomfort in sharing information about yourself and your experience. Any research study on social and personal issues has the potential of an emotional reaction from the participant. Should I conclude that the information you have shared left you feeling emotionally upset or perturbed, I am obliged to refer you to a counsellor for debriefing or counselling, should you agree thereto.

THE POTENTIAL BENEFITS THAT MAY COME OF THIS STUDY

By participating in this research study, you will contribute towards a better understanding of the experiences of tertiary students with unplanned pregnancies and/or who have terminated a pregnancy. Your views and suggestions, as a student experiencing this phenomenon, specifically about the support needs of tertiary students

in this regard, will add great value to the study. It will enable and assist me to formulate guidelines for psychosocial support directed at service providers to respond to the psychosocial needs of tertiary students presenting with unplanned pregnancies and/or TOP's.

ENSURING CONFIDENTIALITY AND ANONYMITY IN THE STUDY

With your permission, the interview that I will conduct with you will be recorded. You will be requested to sign an informed consent form for this purpose. All the information obtained during the course of this study will however be strictly confidential. The recorded interview, which will be transcribed, as well as your letter, will be coded to disguise any identifying information. The digital recording will be kept in a safe place and only the transcriber and I will have access to it. The transcript of the interview and your letter, without any identifying information, will be made available to my research promoter and an independent coder with the sole purpose of assisting and guiding me with this research endeavor. All digital recordings, transcripts and personal documents (letters) will be destroyed five years after completion of this research study.

The results of this study might be published in a journal and/or presented at a meeting or conference, but again without revealing the identity of any participant.

RELEASE OF FINDINGS

Should you require feedback regarding the outcome of this research study, you are welcome to contact me and I will provide you with a written report.

ETHICAL APPROVAL OF THIS STUDY

This study has been approved by the Research and Ethics Committee (DR&EC) of the Department of Social Work at UNISA, as well as the Research and Ethics Committee's

of the participating tertiary institutions⁵⁵. Should you have any questions not sufficiently answered by me as the researcher, you may contact the chairperson of the Research and Ethics Committee at UNISA:

Prof A.H Alpaslan

Telephone number: 012 429 6739

E-mail: alpash@unisa.ac.za

If, after you have consulted with me and the Research and Ethics Committee in the Department of Social Work at UNISA, our answers have not satisfied you, you may direct your questions/concerns/queries to:

The Chairperson

Human Ethics Committee

College of Human Science

P.O Box 392

Unisa

0003

CONTACT DETAILS

Please do not hesitate to contact me, should you require any additional information regarding this research study:

Lynette Conradie

Telephone: 083 776 3989 (office hours)

E-mail: conradie2018@gmail.com

⁵⁵ These documents are available for your perusal- Please contact me, should you wish to be provided with a copy of the ethical approvals and permissions.

A FINAL WORD

Your participation in this study will be greatly appreciated. Should you decide to participate in this research study, you are kindly requested to sign the attached declaration form and leave it with the service provider who gave you this invitation.

DECLARATION

I hereby declare that I have read the contents of the invitation to participate in a research study.

I am willing to participate in this research study and hereby give the researcher permission to contact me in order to arrange a meeting with me for the purpose of conducting the research.

Initial and surname: _____

Signature: _____

Telephone Number: _____

Date: _____



Invitation to participate in a research study

Service providers rendering support services to tertiary students with unplanned pregnancies and/or TOP's

Research Topic:

“Tertiary students’ experiences and needs related to unplanned pregnancy and the termination of pregnancy (TOP): Practice guidelines for psychosocial support”.

Researcher: Lynette Conradie: M.A Soc.Sci (Clinical)

Research promoter: Prof A.H. Alpaslan: Department of Social Work, UNISA

Dear research participant

I am a social worker employed at a tertiary institution in Pretoria (Tshwane)⁵⁶, Gauteng, and also a doctorate student in the Department of Social Work at the University of South Africa (UNISA). In fulfillment of the requirements for this degree, I have to undertake a research project. In view of the fact that you are well-informed about the topic, I hereby approach you with an invitation to participate in this research study.

This invitation contains information regarding the study: Please read it, as it will assist you in your decision whether to participate in the study. It is important that you ensure

⁵⁶ The name of the institution is withheld for the purpose of honoring and maintaining anonymity and confidentiality and the institution/the researcher's place of employ is consequently referred to as *Tertiary Institution D*.

that you fully understand what is involved in the study and that you are satisfied with all aspects of it, before you agree to participate.

THE PURPOSE OF THE STUDY

This research project originated as a result of concern about the significant increase in unplanned pregnancies and the termination of pregnancies (TOP) amongst students at tertiary institutions – these phenomena have become a national and international concern and it poses a multiplicity of problems for students, their significant others and academic institutions: It accounts for a high dropout rate that results in serious financial costs incurred by the institution, the student and her family and it has also been identified as one of the factors affecting the throughput targets of tertiary institutions.

An unmarried student at a tertiary institution, experiencing an unplanned pregnancy, usually finds herself in the midst of a multifaceted crisis for which she has to find a solution as soon as possible. None of the available options, namely parenting, adoption or termination of the pregnancy, is easy and usually has far-reaching implications for the student as well as the tertiary institution.

The emotional impact of the crisis pregnancy, which often ends in the termination of the pregnancy, furthermore has a detrimental effect on the student's well-being, relationships and ultimately also her academic performance.

There is pressure on tertiary institutions to address high student dropout rates and increase their throughput rates. Universities are encouraged to not only investigate this problem, but also design intervention strategies whereby it could be addressed effectively.

There seem to be a lack in social technologies (i.e. strategies, programmes, suggestions or guidelines), based on the experiences and needs of students confronted with an unintended pregnancy and/or TOP, to assist and support them in this regard.

The purpose of my research is therefore to formulate guidelines for psychosocial support, from the ambit of social work, directed at service providers to respond to the psychosocial needs of tertiary students who had an unplanned pregnancy and/or terminated an unplanned pregnancy. Mentioned guidelines are to be informed by and based on the experiences, needs of tertiary students presenting with an unplanned pregnancy and/or TOP as well as their suggestions for psychosocial support to students presenting with this phenomena. The guidelines are also to be informed by the perceptions of service providers rendering psychosocial support services to tertiary students presenting with an unplanned pregnancy and/or TOP about the experiences and support needs of these students; the scopes of the support services offered to them and their suggestions for psychosocial support to said students.

Your perceptions of the experiences and support needs of tertiary students confronted with an unplanned pregnancy and/or TOP, the scopes of the support services that you provide to tertiary students confronted with an unplanned pregnancy and/or TOP as well as your suggestions to inform practice guidelines for psychosocial support, will therefore be explored. This will enhance my insight in and understanding of these matters, which in turn will assist me to proffer guidelines for psychosocial support to tertiary students confronted with an unplanned pregnancy and/or TOP.

CRITERIA FOR INCLUSION

You are invited to participate in this research study because of your experience and knowledge related to your service delivery to tertiary students with unplanned pregnancies and/or TOP. You are able to share your perceptions about the experiences and support needs of this client system group and you are able to make suggestions for informing practice guidelines for psychosocial support to tertiary students confronted with an unplanned pregnancy and/or TOP. The purpose of this research study is not to evaluate your service delivery but rather to develop insight in and a better understanding of the scopes of the support services offered to tertiary students in this regard. You furthermore meet the inclusion criteria for this study, namely:

- You are a service provider (healthcare professional, social worker, psychologist or volunteer counsellor) rendering support services to tertiary students with unplanned pregnancies and/or TOPs
- You are employed at one of the four participating tertiary institutions in Gauteng, or
- You are a volunteer counsellor at the satellite office of a crisis pregnancy care centre (CPCC) that was established on one of the campuses of one of the participating tertiary institutions, or
- You are a volunteer counsellor at the head office of said CPCC in Pretoria (Tshwane).

WHAT WILL BE REQUIRED FROM YOU?

If you decide to participate in the study, the following will be requested from you:

- As discussed and explained during the meeting I had with you on _____ (date), you are requested to act as a “gatekeeper”, identifying and regulating access to the client system group (tertiary students with unplanned pregnancies and/or TOPs).
- You are invited to participate in a focus group discussion, which will be arranged for a time and place that is convenient for you. This focus group will consist of service providers and the purpose of this group will be to share your perceptions of the experiences and support needs of tertiary students with unplanned pregnancies and/or TOPs, to reflect on the scopes of the support services offered to this client system group and to make suggestions for informing the practice guidelines for psychosocial support. Be assured that your opinion and views will be respected and appreciated and that it will make a valuable contribution to this research study.
- You will be requested to sign an informed consent form.

- The following questions will be directed to you during the focus group discussion:

Biographical questions:

- *How old are you?*
- *What is your occupation?*
- *What is your highest qualification?*
- *How long have you been rendering support services to tertiary students, either in the field of higher education or as a volunteer counselor?*

Questions pertaining to the topic under investigation:

- *What are your views in general about the phenomenon of unplanned pregnancies and TOPs amongst tertiary students?*
- *What are your perceptions on the experiences and support needs of tertiary students in relation to their unplanned pregnancies and TOPs?*
- *What are the scopes of the support services that you offer to tertiary students presenting with unplanned pregnancies and/or TOPs?*
- *Based on your experiences as service providers rendering support services to students presenting with UPs and/or TOPs, what suggestion(s) do you have on how these students can be supported by service providers in practice?*

- It is estimated that this meeting will last approximately 90 minutes.

YOUR RIGHTS AS A PARTICIPANT IN THIS STUDY

Your participation in this research study is entirely voluntary and you have the right to withdraw at any time, without needing to give a reason for your decision.

POSSIBLE EFFECTS OF THE STUDY ON YOU AS A PARTICIPANT

No foreseeable discomfort or inconvenience as a result of your participation is expected. Any research study on social and personal issues does however have the potential of an emotional reaction from the participant. Should I conclude that the information you have shared during the focus group discussion left you feeling emotionally upset or perturbed, I am obliged to refer you for debriefing or counselling, should you agree thereto.

THE POTENTIAL BENEFITS THAT MAY COME OF THIS STUDY

By participating in this research study, you will contribute towards a better understanding of the experiences and support needs of tertiary students with unplanned pregnancies and/or TOP's. Your perceptions and suggestions, as a service provider rendering support to this client system group, will add great value to the study and it will enable me to formulate guidelines for psychosocial support. It is envisaged that these guidelines will assist you in your service delivery to tertiary students with unplanned pregnancies and/or TOP's.

ENSURING CONFIDENTIALITY AND ANONYMITY IN THE STUDY

With your permission, the focus group discussion will be recorded. You will be requested to sign an informed consent form for this purpose. All the information obtained during the course of this study, will however be strictly confidential. The recorded focus group discussion, which will be transcribed, will be coded to disguise any identifying information. The digital recording will be stored in a safe place and only the transcriber and I will have access to it. The transcript of the focus group discussion, without any identifying information, will be made available to my research promoter and an independent coder with the sole purpose of assisting and guiding me with this research endeavour. All digital recordings and transcripts will be destroyed five years after completion of this research study.

The results of this study might be published in a journal and/or presented at a meeting or conference, but again without revealing the identity of any participant.

ETHICAL APPROVAL OF THIS STUDY

This study has been approved by the Research and Ethics Committee (DR&EC) of the Department of Social Work at UNISA, as well as the Research and Ethics Committee's of the participating tertiary institutions⁵⁷. Should you have any questions not sufficiently answered by me as the researcher, you may contact the chairperson of the Research and Ethics Committee at UNISA:

Prof A.H Alpaslan

Telephone number: 012 429 6739

E-mail: alpash@unisa.ac.za

If, after you have consulted with me and the Research and Ethics Committee of the Department of Social Work at UNISA, our answers have not satisfied you, you may direct your questions/concerns/queries to:

The Chairperson

Human Ethics Committee

College of Human Science

P.O Box 392

Unisa

0003

CONTACT DETAILS

⁵⁷ These documents are available for your perusal- Please contact me, should you wish to be provided with a copy of the ethical approvals and permissions.

Please do not hesitate to contact me, should you require any additional information regarding this research study:

Lynette Conradie

Telephone: 083 776 3989 (office hours)

E-mail: conradie218@gmail.com

A FINAL WORD

Your participation in this study will be greatly appreciated. Should you decide to participate in this research study, I will make the necessary arrangements with you for conducting the focus group discussions.



INFORMED CONSENT

Tertiary students

“Tertiary students’ experiences and needs related to unplanned pregnancy and the termination of pregnancy (TOP): Practice guidelines for psychosocial support”.

REFERENCE NUMBER:

PRINCIPAL RESEARCHER:

Lynette Conradie

Contact number: 083 776 3989

E-mail: conradie2018@gmail.com

DECLARATION BY PARTICIPANT:

I hereby confirm the following:

- I have been informed of the nature and purpose of this research study
- No pressure was put on me to consent to participate in this study and I understand that I can withdraw from the study at any time without providing a reason for my decision
- I understand that service delivery to me will not be compromised in any way as a result of my decision to participate or not

- The method of data collection, namely an in-depth, semi-structured face-to-face interview and the opportunity to add, share or reflect on additional information regarding my experience and needs by writing a letter, have been explained to me. The interview guide has also been explained to me.
- I give permission for the interview to be digitally recorded
- I understand that all the information obtained in this research study will be dealt with in the strictest confidence
- I understand that only the researcher, her promoter, the transcriber and independent coder will have access to the data collected and that my identity will not be revealed in any discussion, description or publication
- I am aware that I may request to be informed of the results and outcome of this study
- I identify the following possible risks associated with participation in this study:

- I identify the following possible benefits that may come from this study as a result of my participation:

- I understand all the information that was explained to me

I HEREBY CONSENT TO VOLUNTARILY PARTICIPATE IN THIS RESEARCH STUDY:

Participant signature

Date

DECLARATION BY RESEARCHER:

I, Lynette Conradie, hereby confirm the following:

- I am the principal researcher of this project
- I have explained above mentioned information to the participant
- I have given her the opportunity to ask questions regarding the research study

Researcher signature

Date



INFORMED CONSENT

Service providers

“Tertiary students’ experiences and needs related to unplanned pregnancy and the termination of pregnancy (TOP): Practice guidelines for psychosocial support”.

REFERENCE NUMBER: _____

PRINCIPAL RESEARCHER: Lynette Conradie
Contact number: 083 76 3989
E-mail: conradie2018@gmail.com

DECLARATION BY PARTICIPANT:

I hereby confirm the following:

- I have been informed of the nature and purpose of this research study
- No pressure was put on me to consent to participate in this study and I understand that I can withdraw from the study at any time without providing a reason for my decision
- The method of data collection, namely focus group discussions, as well as the discussion guide, have been explained to me
- I give permission for the interview to be digitally recorded

- I acknowledge the importance of ensuring the confidentiality of the discussions between the focus group participants and I agree to not share the content of these discussions with anyone, including my fellow focus group participants, outside of the focus group context.
- I understand that all the information obtained in this research study will be dealt with in the strictest confidence
- I understand that only the researcher, her promoter, the transcriber and the independent coder will have access to the data collected and that my identity will not be revealed in any discussion, description or publication
- I have been informed that the results of this study will be disseminated to me by means of a written report
- I identify the following possible risks associated with participation in this study:

- I identify the following possible benefits that may come from this study as a result of my participation:

- I understand all the information that was explained to me

I HEREBY CONSENT TO VOLUNTARILY PARTICIPATE IN THIS RESEARCH STUDY:

Participant signature

Date

DECLARATION BY RESEARCHER:

I, Lynette Conradie, hereby confirm the following:

- I am the principal researcher of this project
- I explained above mentioned information to the participant
- I have given him/her the opportunity to ask questions regarding the research study

Researcher signature

Date



INTERVIEW GUIDE:
IN-DEPTH, SEMI-STRUCTURED FACE-TO-FACE INTERVIEW WITH
TERTIARY STUDENTS

Questions formulated in order to obtain biographical information:

- *How old are you?*
- *What course of study are you enrolled for?*
- *For which year of study are you currently registered?*
- *Where are you residing (I.e. University accommodation such as a residence or commune; or private accommodation such as a flat)?*
- *In which province do you live when not at university?*
- *How would you describe the area you grew up in (I.e. Urban, semi urban, rural)*

Questions formulated in order to gather information about the topic under investigation:

Opening request: *Can you please describe, in as detailed a manner as possible, your situation when you experienced your UP?*

Further probing requests and questions (only to be asked if needed):

- *What would you say were the reasons for your UP?*
- *Share with me what your personal circumstances were at the time of your UP?*
- *Think back and share with me the feelings/emotions that you experienced when you realised that you were pregnant?*

Follow up central request 1: *Please share with me how the UP that you had experienced changed your life.*

Follow-up central request 2: *Share with me how you dealt with your UP...*

Further probing requests and questions in response to the second follow-up central request:

- *Tell me about the factors that influenced the decision that you have taken in order to deal with your UP...*
- *What feelings/emotions did you experience as a result of your decision taken to deal with your UP?*

Follow up central request 3: *Please tell me about the types of support that you received in relation to your UP and/or TOP?*

a)... on campus...

b)... off campus ...

Further requests and probing questions:

- *Share with me how you experienced the support that you received*
- *Looking back on the support that you received, what would you have liked to be different in terms thereof?*

Follow up central request 4: *Based on your experience as a tertiary student who had an UP and/or a TOP, what suggestion(s) do you have on how students who present with an UP and/or TOP could/should be supported ...*



DISCUSSION GUIDE:
FOCUS GROUP DISCUSSION WITH SERVICE PROVIDERS

Questions formulated in order to obtain biographical information:

- *How old are you?*
- *What is your occupation?*
- *What is your highest qualification?*
- *How long have you been rendering support services to tertiary students, either in the field of higher education or as a volunteer counsellor?*

Questions formulated in order to gather information about the topic under investigation:

- *What are your views in general about the phenomenon of UPs and TOPs amongst tertiary students?*
- *What are your perceptions on the experiences and support needs of tertiary students in relation to their UPs and TOPs?*
- *What are the scopes of the support services that you offer to tertiary students presenting with UPs and/or TOPs?*
- *Based on your experiences as service providers rendering support services to students presenting with UPs and/or TOPs what suggestion(s) do you have on how these students can be supported by service providers in practice?*



**PROOF OF ETHICAL CLEARANCE
DEPARTMENT OF SOCIAL WORK
UNIVERSITY OF SOUTH AFRICA**

Declaration

Reference number: 41751671_13/04/10_01

I, the undersigned, hereby declare that the research proposal together with the supportive documentation detailing the ethical considerations will be adhered to during entire research process was submitted for review and ethical approval to the Department of Social Work's Departmental Research and Ethics Committee at a meeting held on 13 April 2010.

Title: TERTIARY STUDENTS' EXPERIENCES AND NEEDS RELATED TO UNPLANNED PREGNANCIES AND THE TERMINATION OF PREGNANCY: PRACTICE GUIDELINES FOR PSYCHOSOCIAL SUPPORT

Qualification: DPhil in Social Work

Name of the student: Mrs L Conradie
Adres: 176 Tom Jenkins Drive, Rietondale, 0084
Cell Number: 083 7763989
Student Number: 41751671

Final approval and ethical clearance is granted for the duration of the project.

The proposed research may now commence with the proviso that:

- 1) The researcher will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
- 2) Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Department of Social Work's Research and Ethics Review Committee. An amended application could be requested of there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the participants.
- 3) The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.



Signature: _____

Prof AH Alpaslan

Chair: Departmental Research and Ethics Committee

Date: 13 April 2010